89 12859

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE WILLIAM AMAN | | | 2. DATE OF DEATH (Month, Day, Year): 05/16/89 | 3. TIME OF DEATH: 8:10P M |
| 4. SOCIAL SECURITY NUMBER: 214055017 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07-21-1916 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: cumberland | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 320 S. Cedar Street | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bottling House | 16b. KIND OF BUSINESS/INDUSTRY: Brewery | | |
| 17. FATHER'S NAME (First, Middle, Last): George W. Aman, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Mackert | | |
| 19a. INFORMANT'S NAME (Type/Print): John A. Aman, Sr. Samuel Lisanti | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Marys Cemetery | 20c. LOCATION — City or Town, State: Cumberland, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home 108 Virginia Avenue, Cumberland, MD 21502 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreat, ahock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Acute Renal failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. Acute Peritonitis
OUE TO (OR AS A CONSEQUENCE OF):
c. Ruptured Cecum, Closed loop by
DUE TO (OR AS A CONSEQUENCE OF):
d. Cancer Sigmoid Colon

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
Cerebra Vascular accident, Rt hemisphere

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| R Fadl | 16150 | ▶ 5.17.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR RAGAA FADL 921 SETON DRIVE CUMBERLAND MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 18 1989 | [signature] |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12860

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGIA V. APPOLD | | | | 2. DATE OF DEATH (Month, Day, Year): May 15, 1989 | 3. TIME OF DEATH: 7:00 PM |
| 4. SOCIAL SECURITY NUMBER: 207-46-4290 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): April 20, 1905 | 8. BIRTHPLACE (State or Foreign Country): W.Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: W.Va. | 10b. COUNTY: Morgan | 10c. CITY, TOWN OR LOCATION: Paw Paw | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. #1 Box 6 | | 10f. ZIP CODE: 25434 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Dmestic | |
| 17. FATHER'S NAME (First, Middle, Last): James W. Hare | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Gates | |
| 19a. INFORMANT'S NAME (Type/Print): Jime Morgan | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. #1 Box 180A MT. Savage, Md. 21545 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Camp Hill Cemetery | | 20c. LOCATION — City or Town, State: Paw Paw W.Va. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Luis A. Braithwaite | | 22. NAME AND ADDRESS OF FACILITY: Helsley-Johnson Funeral Home Berkeley Springs, W.Va. 25411 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

2

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular Tachycardia | Minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease | Years. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Cerebro vascular accident

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Sunil Gupta MD | D 33280 | ▶ 5/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Sunil Gupta, Memorial Hospital Medical Building, Cumberland, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 23 1989 | Julia Dawson-Kendall |

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12861

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| LOUIS | AUGUST | ARNOLD | 05 / 13 / 89 | 1:45pm M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 712-141-523 | 1 X M 2 ☐ F | 71 YRS. | | | 10/29/1917 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| SACRED HEART HOSPITAL | Cumberland | ALLEGANY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Allegany | Mt. Savage | 1 ☐ YES 2 X NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Rt. 1, Box 206 | 21545 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 X NO | 1 ☐ YES 2 X NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | | Foreman | Tire Co. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Daniel H. Arnold Sr. | Ruth Miller |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Louise Arnold | Rt. 1, Box 206, Mt. Savage, Md. 21545 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) Entombment | Rest Lawn Memorial Gardens | La Vale, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ John P. Horn | Durst Funeral Home, Frostburg, Md. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Advanced Ca. Prostate | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☑ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D23371 | ▶ 5/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. QAMAR ZAMAN MEMORIAL MEDICAL BLDG. CUMBERLAND, MD. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 16 1989 | Jackie Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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89 12861

#61

89 12862

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELLA JEAN BURKE | | | | 2. DATE OF DEATH (Month, Day, Year): 5-4-89 | 3. TIME OF DEATH: 4:20P M |
| 4. SOCIAL SECURITY NUMBER: 215206606 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/27/21 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, MD | | 9c. COUNTY OF DEATH: ALLEGANY COUNTY |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: WV | 10b. COUNTY: Hampshire | 10c. CITY, TOWN OR LOCATION: Ridgeley | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 53 Potomac Street | | 10f. ZIP CODE: 26753 | | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | |
| 19a. INFORMANT'S NAME (Type/Print): Sacred Heart Hospital | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 900 Seton Drive, Cumberland, MD 21502 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Omega Crematory | | 20c. LOCATION — City or Town, State: Morgantown, WV | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: WVU/HGR, Morgantown, WV | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatorenal failure due to Cirrhosis of liver | 8 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

| | | | |
|---|---|---|---|
| | | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Andrew Stasko IV | | ▶ 5/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): DR A STASKO 924 SETON DR CUMBERLAND, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| JUN 09 1989 | [signature] |

DHMH-16 Rev 1/89

89 12863

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sara Rosenbaum Beneman | | | 2. DATE OF DEATH (Month, Day, Year): May 14, 1989 | 3. TIME OF DEATH: 2:00 A.M |
| 4. SOCIAL SECURITY NUMBER: 218-48-9595 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9-17-1903 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Washington & Lee Apts. 12 S. Lee St. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: Allegany | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 12 South Lee Street | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Jewish |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beneman'S Furniture | 16b. KIND OF BUSINESS/INDUSTRY: Furniture |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Rosenbaum | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Antoinette Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Jay Beneman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 Wyndmoor Avenue Philadelphia, Pa. 19118 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): East view Cemetery | 20c. LOCATION — City or Town, State: Cumberland, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest A. Ridgely Jr. | | 22. NAME AND ADDRESS OF FACILITY: Leasure-Stein Funeral Home 230 Baltimore Ave. Cumberland, Md 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Astrocytoma Left Parietal Lobe | 7 Mos. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status Surgery for Brain Tumor, Mild Diabetes Mellitus, Dehydration, Hypokalemia

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|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Samuel Jacobson | 29c. LICENSE NUMBER: (Md.) DO5209 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samuel M. Jacobson, M. D. 50 Pershing St., Cumberland, Md. 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12864

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages ___ should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE EDGAR BROWN | | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 04 / 89 | 3. TIME OF DEATH: 1735 P M |
| 4. SOCIAL SECURITY NUMBER: 214-07-3806 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | | 7. DATE OF BIRTH (Month, Day, Year): 03/25/1906 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): CUMBERLAND MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND | | 9c. COUNTY OF DEATH: ALLEGANY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: PA | 10b. COUNTY: BEDFORD | 10c. CITY, TOWN OR LOCATION: HYNDMAN | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: R D 1, BOX 531 | | 10f. ZIP CODE: 15545 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR | 16b. KIND OF BUSINESS/INDUSTRY: ENGINEERING | |
| 17. FATHER'S NAME (First, Middle, Last): GEORGE NELSON BROWN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA MAE MADDEN | |
| 19a. INFORMANT'S NAME (Type/Print): EVELYN MAYE BROWN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R D 1, BOX 531, HYNDMAN, PA 15545 | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HYNDMAN CEMETERY | 20c. LOCATION — City or Town, State: HYNDMAN, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harvey H Zeigler Jr | | 22. NAME AND ADDRESS OF FACILITY: HARVEY H. ZEIGLER FUNERAL HOME CLARENCE STREET, HYNDMAN, PA 15545 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. ASHD | yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. CAD | yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | d. Cardiac Angioma - Atrial Fibrillation | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John T Whitmore MD | 29c. LICENSE NUMBER: D19229 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-6-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. John T. Whitmore, P.O. Box 3675, LaVale, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 08 1989 | 32. REGISTRAR'S SIGNATURE: Sylvia Davidson-Mitchell |

6

DHMH-16 Rev 1/89

89 1286

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12865

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HENRY CHRISTIAN BOCKES | | | | 2. DATE OF DEATH (Month, Day, Year): MAY 2, 1989 | 3. TIME OF DEATH: 9:45 A M |
| 4. SOCIAL SECURITY NUMBER: 208105035 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan 24 1912 | 8. BIRTHPLACE (State or Foreign Country): Pa. |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH: ALLEGANY COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Pa | 10b. COUNTY: Somerset | 10c. CITY, TOWN OR LOCATION: RD1 Meyersdale | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: RD1 | | 10f. ZIP CODE: 15552 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Coal Miner | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel W. Bockes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ollive Haer | |
| 19a. INFORMANT'S NAME (Type/Print): Mary S. Bockes | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD1 Box 58 Meyersdale, Pa. 15552 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Highland Cemetery | 20c. LOCATION — City or Town, State: Garrett, Pa. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Ray Leckemby | | 22. NAME AND ADDRESS OF FACILITY: M. Ray Leckemby Funeral Home 203 North St Meyersdale, Pa. 15552 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute respiratory Failure
acute LL Pneumonia / Mass
acute renal Failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Orlino M.D. | 29c. LICENSE NUMBER: D34846 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): ROBERT ORLINO, M.D. 900 SETON DRIVE CUMBERLAND, MD. 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Jeba Davidson-Randall |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OE DEATH

89 12866
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ___ should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): AVIS ODELL COMER | | | | 2. DATE OF DEATH (Month, Day, Year): 5-18-89 | 3. TIME OF DEATH: 7:26P M |
| 4. SOCIAL SECURITY NUMBER: 234388618 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-29-1927 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: WV | 10b. COUNTY: Mineral | 10c. CITY, TOWN OR LOCATION: Ridgeley | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: Third Avenue | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: Korean | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Glass | |
| 17. FATHER'S NAME (First, Middle, Last): Redford J. Comer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Comer | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Bettie Bujac | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park | 20c. LOCATION — City or Town, State: Cumberland, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home 108 Virginia Avenue, Cumberland, MD 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac Dr respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Cancer to liver | 2 mo. |
| DUE TO (OR AS A CONSEQUENCE OF): | Lung Cancer | 1 yr |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive Lung Disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R Schmitt MD | 29c. LICENSE NUMBER: D26333 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR R SCHMITT PULMONARY MEDICINE SACRED HEART HOSPITAL CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Faidley-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12867

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edna Pearl Carscaden
2. DATE OF DEATH (Month, Day, Year): 5 14 89
3. TIME OF DEATH: 6:30 PM
4. SOCIAL SECURITY NUMBER: 236-58-2922
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): 06-19-1907
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): 50 Gleason Street
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 50 Gleason Street
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife
16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): Robert Rice
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Moore
19a. INFORMANT'S NAME (Type/Print): Cynthia M. Weber
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 50 Gleason Street, Cumberland, MD 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SS Peter Paul Cemetery
20c. LOCATION — City or Town, State: Cumberland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-pulmonary arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Parkinsonism | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Rheumatoid arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dpty Med. Ex
29c. LICENSE NUMBER: D09157
29d. DATE SIGNED (Month, Day, Year): 5/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Snow M.D. 124 W. 3rd St. Cumberland Md
31. DATE FILED (Month, Day, Year): MAY 16 1989
32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

89 12867

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12868
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES EDWARD CANNON SR. | | | | 2. DATE OF DEATH (Month, Day, Year): May 18, 1989 | 3. TIME OF DEATH: 6:30 PM |
| 4. SOCIAL SECURITY NUMBER: 220-38-0763 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 45 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JANUARY 9 1944 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ALLEGANY | 10c. CITY, TOWN OR LOCATION: CUMBERLAND | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 310 BELLEVUE HEIGHTS | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: usa |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: DEC 1961-MARCH 1963 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th GED; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AIDE | 16b. KIND OF BUSINESS/INDUSTRY: HOSPITAL | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN WILLIAM MARCELLUS CANNON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELEANOR MESSENGER | |
| 19a. INFORMANT'S NAME (Type/Print): DARLENE J. CANNON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 BELLEVUE HEIGHTS CUMBERLAND MARYLAND 21502 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HILLCREST BURIAL PARK | 20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt | | 22. NAME AND ADDRESS OF FACILITY: SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE ANTERIOR MYOCARDIAL INFARCTION | 2 HOURS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. SEVERE C.A.D. | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William Cann MD | 29c. LICENSE NUMBER: D 25406 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Anthony Bollino, Frederick Street, Cumberland, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Gisela Davidson-Randall |

OHMH-16 Rev 1/89

89 12869

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SARA BIRDELLA CLEM | | | 2. DATE OF DEATH: MONTH 05 DAY 17 YEAR 89 | 3. TIME OF DEATH: 20:40pm M |
| 4. SOCIAL SECURITY NUMBER: 219-14-5779 | 5. SEX: 1 ☐ M 2 ☒ F X | 6. AGE (In yrs. last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 27, 1923 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: WV | 10b. COUNTY: Mineral | 10c. CITY, TOWN OR LOCATION: Keyser | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt.2 Silver Tree Apt.#101 Keyser, WV | | 10f. ZIP CODE: 26726 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Test Lab Tech. | 16b. KIND OF BUSINESS/INDUSTRY: Celanese Fibers Corp. | |
| 17. FATHER'S NAME (First, Middle, Last): Carl Knipple | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Lease | | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia Liller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 100C, Keyser, WV 26726 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Forest Glen Cemetery | 20c. LOCATION — City or Town, State: Green Spring, WV | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wendy N. Yochum | 22. NAME AND ADDRESS OF FACILITY: Fort Ashby Funeral Home P.O.Box 1260 Fort Ashby, WV 26719 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Ca | ? |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Ca of lung } diagnosed several mos. ago | ? |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A. B. Flores MD | 29c. LICENSE NUMBER: DO 15351 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. AUDBERTO FLORES 924 SETON DR. CUMBERLAND, MD. 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Judith Faidley Randall |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 or 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMN-18 Rev 1/89

89 1286a

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12870

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH / DAY / YEAR | | 3. TIME OF DEATH | |
| John W Coburn Sr. | | | | 5/07/89 | | 9:35p | M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) | |
| 218 12 5705 | 1 [X] M 2 [ ] F | 64 YRS. | | 8/24/24 | | Md | |
| 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH | | | |
| Frostburg Community Hospital | | Frostburg MD | | Allegany | | | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | Allegany | Lonaconing | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 12 St Mary's Terrace | 21539 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES WW II | 1 [ ] YES 2 [X] NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Tire-Builder | Kelly Springfield Tire Co. |
| 11 | 0 | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Larry Coburn | Elsie Arnold |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rose Marie Coburn | 12 St.Marys Terrace,Lonaconing,Md. 21539 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Frostburg Mem. Park | Frostburg,Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James E McKenzie | Eichhorn-McKenzie Funeral Home Lonaconing,Md. 21539 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory failure DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Carcinoma of lung DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Chronic obstructive lung disease DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Shin E. Kim | D15463 | ▶ 5/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Shin E. Kim 90 West Main Street Westernport, MD 21562

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Julia Davidson-Rondeau |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12871
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

2

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Daniel Henry Dahl, Sr. | | | 2. DATE OF DEATH (Month, Day, Year): May 22, 1989 | 3. TIME OF DEATH: 12:46 P M |
| 4. SOCIAL SECURITY NUMBER: 216-18-1348 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): March 28, 1901 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 427 N. Centre Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] ND |
| 10e. STREET AND NUMBER: 427 N. Centre Street | | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian | | 16b. KIND OF BUSINESS/INDUSTRY: Private |
| 17. FATHER'S NAME (First, Middle, Last): William Dahl | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rachel Beal | | |
| 19a. INFORMANT'S NAME (Type/Print): Daniel Henry Dahl, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 213 Washington Street, Cumberland, MD 21502 | | |
| 20a. METHDD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 6 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Omps Crematory | | 20c. LOCATION — City or Town, State: Winchester, VA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Henry D. Upchurch | | 22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the desth. Do not enter the mode of dying, such ss csrdiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEDUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Cardiovascular Diease
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes Mellitus
DUE TO (DR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Diease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HDW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Snow MD ME
29c. LICENSE NUMBER: D09157
29d. DATE SIGNED (Month, Day, Year): ▶ 5/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print): Dr. Paul Snow, M.D. Deputy Med. Ex. 124 W. 3rd St. Cumb, MD 21502

31. DATE FILED (Month, Day, Year): MAY 23 1989
32. REGISTRAR'S SIGNATURE: Julia Gardner Rinehart

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12872

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): REBA MAE DOMMEL | | | | 2. DATE OF DEATH (Month, Day, Year): 05-11-1989 | 3. TIME OF DEATH: 8:10 A. M |
| 4. SOCIAL SECURITY NUMBER: 578-30-5935 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-21-1926 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): Route 1 Box 134A | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Route 1 Box 134A - Cash Valley Road | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Publishing | 16b. KIND OF BUSINESS/INDUSTRY: McGraw-Hill Publishing Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Goerge E. Corbin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia L. Grimes | |
| 19a. INFORMANT'S NAME (Type/Print): John F. Dommel, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 1 Box 134A, Cumberland, Md 21502 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Restlawn Memorial Gardens | 20c. LOCATION — City or Town, State: LaVale, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-Respiratory Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Advanced Endometrial Ca.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Qamar Zaman, M.D., Memorial Hospital Medical Bldg., Cumberland, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson Randall |

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DHMH-16 Rev 1/89

89 12872

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12873
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elizabeth NMI Durst | | | 2. DATE OF DEATH (Month, Day, Year): 5 4 89 | 3. TIME OF DEATH: 23:15 M |
| 4. SOCIAL SECURITY NUMBER: 212-74-5471 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03/08/07 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg MD | | 9c. COUNTY OF DEATH: Allegany |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 12018 McMullen Highway | | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last): George Lewis | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Walbott | | |
| 19a. INFORMANT'S NAME (Type/Print): Charles F. Durst | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12018 Mc Mullen Hgy. Cumberland, Md. 21502 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park | 20c. LOCATION — City or Town, State: Frostburg, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John B. Horn | | 22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cerdiec or respiratory errest, shock, or heert feilure. Liet only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIO RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. INTRACTABLE CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. END STAGE ISCHEMIC CARDIOMYOPATHY
DUE TO (OR AS A CONSEQUENCE OF):
d. CORONARY ARTERY DISEASE

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.
DEGENERATIVE ARTHRITIS.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. Chang M.D
29c. LICENSE NUMBER: D 25638
29d. DATE SIGNED (Month, Day, Year): ▶ 5/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR Saturnina Chang, MD Frostburg Plaza Frostburg, MD 21532

31. DATE FILED (Month, Day, Year): MAY 10 1989
32. REGISTRAR'S SIGNATURE:

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12874

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ETHEL BLANCH FAZENBAKER | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 14 / 89 | 3. TIME OF DEATH: 02:45am M |
| 4. SOCIAL SECURITY NUMBER: 236-03-2588 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/21/1898 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, Md. | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Allegang | 10c. CITY, TOWN OR LOCATION: Westernport, Md. | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 304 Linkens St. | | 10f. ZIP CODE: 21562 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): John Green | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Dawson Fazenbaker | |
| 19a. INFORMANT'S NAME (Type/Print): Roger Fazenbaker | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 304 Linkens St. Westernport, Md. 21562 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bloomington, Cemetery | 20c. LOCATION — City or Town, State: Bloomington, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roger L. Swamp | 22. NAME AND ADDRESS OF FACILITY: 111 Church St. Westernport, Md. 21562 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Cardiac Arrest | instant |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute Myocardial Infarction | 6 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Generalized Arteriosclerosis | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Carcinoma of Rectum

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: L.R. Miles MD (medical director) | 29c. LICENSE NUMBER: D09004 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/16/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L.R. MILES MD | BMG-912 SETON DR. CUMBERLAND, MD. 21502 | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE | |

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12875

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): EDITH H. FLANAGAN

**2. DATE OF DEATH** (Month, Day, Year): May 11, 1989

**3. TIME OF DEATH**: 9:01 AM

**4. SOCIAL SECURITY NUMBER**: 232-26-1145

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 90 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Feb 27, 1899

**8. BIRTHPLACE** (State or Foreign Country): WV

**9a. FACILITY NAME** (If not institution, give street and number): Memorial Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Cumberland

**9c. COUNTY OF DEATH**: Allegany

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: Allegany

**10c. CITY, TOWN OR LOCATION**: RAwlings

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: Rt 3 Box 195 A

**10f. ZIP CODE**: 21557

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): Unknown
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

**16b. KIND OF BUSINESS/INDUSTRY**: ----

**17. FATHER'S NAME** (First, Middle, Last): G. F. Harman

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Katie Blankley

**19a. INFORMANT'S NAME** (Type/Print): Margaret Hart

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rd 3 Box 195 A Rawlings, MD 21557

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Cortland Cemetery

**20c. LOCATION — City or Town, State**: Davis, WV

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Rotruck

**22. NAME AND ADDRESS OF FACILITY**: Rotruck Funeral Home, 85 South Main Street Keyser, WV

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** → a. Cerebrovascular Accident — 4/25-5/11

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**

a. ____ DUE TO (OR AS A CONSEQUENCE OF):
b. ____ DUE TO (OR AS A CONSEQUENCE OF):
c. ____ DUE TO (OR AS A CONSEQUENCE OF):
d. ____

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] MD

**29c. LICENSE NUMBER**: D12719

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5/13/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Dr. Guy Fiscus, Memorial Hospital Medical Building, Cumberland, MD. 21502

**31. DATE FILED** (Month, Day, Year): MAY 22 1989

**32. REGISTRAR'S SIGNATURE**

DHMH-6 Rev 1/89

89 12876

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HERBERT WARREN GRAHAM | | | 2. DATE OF DEATH (Month, Day, Year): MAY 21, 1989 | 3. TIME OF DEATH: 11:56 A M |
| 4. SOCIAL SECURITY NUMBER: 051053641 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06-17-1909 | 8. BIRTHPLACE (State or Foreign Country): NY |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: ALLEGANY COUNTY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 841 Mt. Royal Avenue | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): owner | 16b. KIND OF BUSINESS/INDUSTRY: Insurance / Real Estate | |
| 17. FATHER'S NAME (First, Middle, Last): James Patrick Graham | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary McCaw | | |
| 19a. INFORMANT'S NAME (Type/Print): John W. Wilson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Walla Walla, WA | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mountain View Cemetery | 20c. LOCATION — City or Town, State: Walla Walla, WA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James J Scarpelli | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBROVASCULAR ACCIDENT | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ATRIAL FIBRILLATION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ATHEROSCLEROTIC VASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DIABETES MELLITUS | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Sepsis, Deep Vein Thrombosis, Renal Failure, Electrolyte Imbalance, Acidosis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): URIEL VELANDIA, M.D. 924 SETON DRIVE CUMBERLAND, MD. 21502 | | |
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

1 - 5

89 12816

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12877

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clarence L Gaumer
2. DATE OF DEATH (Month, Day, Year): 5 27 89
3. TIME OF DEATH: 7:01 M
4. SOCIAL SECURITY NUMBER: 170 88 18 2179
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4 04 19
8. BIRTHPLACE (State or Foreign Country): Boynton, Pa.
9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg MD
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: PA
10b. COUNTY: Somerset
10c. CITY, TOWN OR LOCATION: Salisbury PA
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt 1 Box 144
10f. ZIP CODE: 15558
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver
16b. KIND OF BUSINESS/INDUSTRY: Trucking
17. FATHER'S NAME (First, Middle, Last): John C Gaumer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Baer
19a. INFORMANT'S NAME (Type/Print): June E Gaumer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 1 Box 144 Salisbury, Pa. 15558
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Salisbury Cemetery
20c. LOCATION — City or Town, State: Salisbury, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Garfield F Thomas
22. NAME AND ADDRESS OF FACILITY: Garfield F Thomas F H 101 Grant St Salisbury, Pa. 15558

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardioplumonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. COPD
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Snow
29c. LICENSE NUMBER: Do9157
29d. DATE SIGNED (Month, Day, Year): ▶ 5/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Snow MD Deputy Medical Examiner 124 W Third St , Cumberland MD 21502
31. DATE FILED (Month, Day, Year): JUN 01 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 1287

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12878
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN M. GRIFFITH | | 2. DATE OF DEATH (Month, Day, Year): May 12, 1989 | 3. TIME OF DEATH: 1:44 P. M |
| 4. SOCIAL SECURITY NUMBER: 217-10-4611 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08-08-1899 |
| 8. BIRTHPLACE (State or Foreign Country): MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 98 Auburn Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: Allegany | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 98 Auburn Avenue | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): secretary | 16b. KIND OF BUSINESS/INDUSTRY: Fabrics Warehouse | |
| 17. FATHER'S NAME (First, Middle, Last): William J. Beasley | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Beall | | |
| 19a. INFORMANT'S NAME (Type/Print): Ramon L. Rice | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 S. Race Street, Denver, CO | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park | 20c. LOCATION — City or Town, State: Cumberland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-Pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriolosclerosis Cardio-Vascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Glaucoma

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Snow DPTY MED EX | 29c. LICENSE NUMBER: D09157 | 29d. DATE SIGNED (Month, Day, Year): ▶ 05-12-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Snow, Dpt. Med. Ex., 124 West Third Street, Cumberland, MD 21502 | | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

89 12878

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12879 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GLEN W. GILLUM | | | 2. DATE OF DEATH (Month, Day, Year): April 6, 1989 | 3. TIME OF DEATH: 1:25 p M |
| 4. SOCIAL SECURITY NUMBER: 219-14-7134 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-05-1927 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, MD 21502 | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: NC | 10b. COUNTY: Craven | 10c. CITY, TOWN OR LOCATION: Havelock | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 104 Stratford Road | | 10f. ZIP CODE: 28532 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): GY SGT. | 16b. KIND OF BUSINESS/INDUSTRY: U.S. MARINE CORP. |

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|---|---|
| 17. FATHER'S NAME (First, Middle, Last): N. Kenneth gillum | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Baker |
| 19a. INFORMANT'S NAME (Type/Print): Jean M. Gillum | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 Stratford Road, Havelock, NC |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Forest Oaks Memorial Gardens | 20c. LOCATION — City or Town, State: Havelock, NC |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, Cumberland, MD 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident — days

DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Edema

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

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|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Fiscus Memorial Hospital Medical Building, Cumberland, MD 21502

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|---|---|
| 31. DATE FILED (Month, Day, Year): APR 07 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12880

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be obtained from the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before cremation.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GRACE ELIZABETH GOODWIN | | | 2. DATE OF DEATH (Month, Day, Year): 05 19 89 | 3. TIME OF DEATH: 02:47am M |
| 4. SOCIAL SECURITY NUMBER: 164-44-2644 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-25-1898 | 8. BIRTHPLACE (State or Foreign Country): Pa. |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: ALLEGANY | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Pa | 10b. COUNTY: Somerset | 10c. CITY, TOWN OR LOCATION: Berlin | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: Maple Mt. Manor | | 10f. ZIP CODE: 15530 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): Elwood Shaffer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Burkett | | |
| 19a. INFORMANT'S NAME (Type/Print): Wilma Bradfield | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 626 Frederick St. Cumberland, Md. | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hyndman Cemetery | 20c. LOCATION — City or Town, State: Hyndman, Pa. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William A. Price II | 22. NAME AND ADDRESS OF FACILITY: Price Funeral Home 325 Main St. Meyersdale, Pa. 15552 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. acute Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
c. acute aspiration
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Orlino

29c. LICENSE NUMBER: D34846

29d. DATE SIGNED (Month, Day, Year): ▶ 5/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DR. ROBERT ORLINO 900 SETON DR. CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year): MAY 25 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12881
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): KATHRYN M. GURTLER | | | | 2. DATE OF DEATH (Month, Day, Year): May 4, 1989 | 3. TIME OF DEATH: 7:10 P.M |
| 4. SOCIAL SECURITY NUMBER: 215-26-6431 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 09-28-1917 | 8. BIRTHPLACE (State or Foreign Country): WV |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 446 Seymour Street | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): secretary | 16b. KIND OF BUSINESS/INDUSTRY: Doctor's Office | |
| 17. FATHER'S NAME (First, Middle, Last): John W. Sidley | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Durham | |
| 19a. INFORMANT'S NAME (Type/Print): Deborah Ann Madden | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Cumberland, MD 21502 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park | 20c. LOCATION — City or Town, State: Cumberland, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home 108 Virginia Avenue, Cumberland, MD 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Atherosclerotic Coronary Vascular Disease. | 30 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Fracture Right Femur

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. R. Starynski MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. John R. Starynski, 925 Seton Drive, Cumberland, MD 21502

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|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 08 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle |

DHMH-16 Rev 1/89

89 12881

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12882
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Kenneth Louis Gingerich | | | 2. DATE OF DEATH (Month, Day, Year): May 2 1989 | 3. TIME OF DEATH: 2:30 P M |
| 4. SOCIAL SECURITY NUMBER: 216-09-4419 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec 16 1914 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 2 Roger Way | | 9b. CITY, TOWN OR LOCATION OF DEATH: LaVale | | 9c. COUNTY OF DEATH: Allegany |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: LaVale | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2 Roger Way | | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY? U S A |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assistant Manager | | 16b. KIND OF BUSINESS/INDUSTRY: Insurance |
| 17. FATHER'S NAME (First, Middle, Last): Louis C. Gingerich | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Harden | | |
| 19a. INFORMANT'S NAME (Type/Print): Emma G. Gingerich | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Roger Way LaVale, Maryland 21502 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Lawn Memorial Gardens | | 20c. LOCATION — City or Town, State: LaVale, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas D. Hafer | | 22. NAME AND ADDRESS OF FACILITY: Hafer Funeral Home LaVale, MD 21502 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic CA of prostate

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| H. Merrick | | ▶ May 4, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. Curtiss Merrick - Memorial Hospital Med. Center Cumb., MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 08 1989 | |

DHMH-18 Rev 1/89

89 12882

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12883
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): WILBUR HOWELL GREENE SR

**2. DATE OF DEATH** (Month, Day, Year): 05 12 89

**3. TIME OF DEATH**: 230 AM M

**4. SOCIAL SECURITY NUMBER**: 243 34 6646

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 1-24-26

**8. BIRTHPLACE** (State or Foreign Country): N.C.

**9a. FACILITY NAME** (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: GLEN BURNIE

**9c. COUNTY OF DEATH**: A.A. COUNTY

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Anne Arundel

**10c. CITY, TOWN OR LOCATION**: Glen Burnie

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 223 S. Hammonds Ferry Rd.

**10f. ZIP CODE**: 21061

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 4 — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker

**16b. KIND OF BUSINESS/INDUSTRY**: Steel Mill

**17. FATHER'S NAME** (First, Middle, Last): Robert Davis

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Johnnie Greene

**19a. INFORMANT'S NAME** (Type/Print): Minerva J. Greene, Wife

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 223 Hammonds Ferry Rd. Glen Burnie, Md. 21061

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens

**20c. LOCATION — City or Town, State**: Baltimore Co., Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Julia Bruzdzinski

**22. NAME AND ADDRESS OF FACILITY**: Bruzdzinski Funeral Home PA 1407 Eastern Ave Balto. Md. 21221

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

**Approximate Interval Between Onset and Death**

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** →
a. Metastatic Malignant Melanoma — 18 months
DUE TO (OR AS A CONSEQUENCE OF):

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: Sepsis

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☑ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☑ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Long S. Hsu

**29c. LICENSE NUMBER**: D20431

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5/12/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23)** (Type/Print): LONG S. HSU, M.D. 300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061

**31. DATE FILED** (Month, Day, Year): MAY 15 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Landers

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12884
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES KELLEY
2. DATE OF DEATH (Month, Day, Year): 05 14 89
3. TIME OF DEATH: 2320 P M
4. SOCIAL SECURITY NUMBER: 220-03-7937
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb 8 1921
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Rt 1 Box 133B Mt. Savage
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Barrelville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 1 Box 133B
10f. ZIP CODE: 21545
10g. CITIZEN OF WHAT COUNTRY?: U S A
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Textile Industry
17. FATHER'S NAME (First, Middle, Last): George C. Kelley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine C. Loar
19a. INFORMANT'S NAME (Type/Print): James K. Friend
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 317 Race Street Cumberland, MD 21502
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Patricks Catholic Cem
20c. LOCATION — City or Town, State: Mt. Savage, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas D. Hafer
22. NAME AND ADDRESS OF FACILITY: Hafer Funeral Home 21502, 1302 National Hwy LaVale, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Generalized Arteriosclerosis

DUE TO (OR AS A CONSEQUENCE OF):

c. Chronic Lung Disease

DUE TO (OR AS A CONSEQUENCE OF):

d. CIGARETTE SMOKING

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: JCookMD
29c. LICENSE NUMBER: D34693
29d. DATE SIGNED (Month, Day, Year): ▶ 5/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JEFF COOK MD ER - CUMBERLAND MEM. HOSP.
31. DATE FILED (Month, Day, Year): MAY 17 1989
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12885

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the Burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOLORES KAY KNIGHT | | | | 2. DATE OF DEATH (Month, Day, Year): 05/06/989 | 3. TIME OF DEATH: 2:45P M |
| 4. SOCIAL SECURITY NUMBER: 234643332 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 45 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 11, 1943 | 8. BIRTHPLACE (State or Foreign Country): W. Va. |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: W. VA. | 10b. COUNTY: Mineral | 10c. CITY, TOWN OR LOCATION: Keyser | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 468 W. Piedmont Street | | 10f. ZIP CODE: 26726 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teachers Aide | 16b. KIND OF BUSINESS/INDUSTRY: School |
| 17. FATHER'S NAME (First, Middle, Last): Frank Fitzgearald | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Inskeep | |
| 19a. INFORMANT'S NAME (Type/Print): Miss Kelly K. Knight | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 468 W. Piedmont St., Keyser, W. Va. 26726 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Queens Point Cemetery | 20c. LOCATION — City or Town, State: Keyser, W. Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold W. McKenzie | | 22. NAME AND ADDRESS OF FACILITY: Markwood Mc Kenzie Funeral Home 111 S. Mineral Street, Keyser, W. Va. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Breast Carcinoma | 3½yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul J. Livengood MD | 29c. LICENSE NUMBER: D23774 | 29d. DATE SIGNED (Month, Day, Year): 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. PAUL LIVENGOOD BMG, 912 SETON DRIVE CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers |

5

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12886
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

N

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Eleanor | May | Keefer | May 18, 1989 | 9:30 AM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-80-8009 | 1 ☐ M 2 ☒ F | 74 YRS. | | | 11-25-1914 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Allegany | Cumberland | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 426 Virginia Avenue | 21502 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | housewife | own home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William Valentine | Elizabeth (nmn) |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ruth E. Keefer | Cumberland, MD 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Hillcrest Burial park | Cumberland, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James F Scarpelli | Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ca of lung | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Peter Halmos MD | | ▶ 5/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Peter Halmos Memorial Hospital Cumberland, Md. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | Julia Davidson Randall |

2

DHMH-16 Rev 1/89

item 16a filmG652 6-27-89 I.J.

Item# 10f, 11, 18 Film#g653 07/28/89 per F.H. da D.J.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12887
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joel Lee Knight,III
2. DATE OF DEATH (Month, Day, Year): 5-22-89
3. TIME OF DEATH: 7:28AM M
4. SOCIAL SECURITY NUMBER: 265-55-7805
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 31 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Jun 3, 1957
8. BIRTHPLACE (State or Foreign Country): Florida
9a. FACILITY NAME (If not institution, give street and number): Rt. 51 S. of Cumberland, Rt.51 Oldtown Rd
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany County

RESIDENCE OF DECEDENT

10a. STATE: Florida
10b. COUNTY: Lee County
10c. CITY, TOWN OR LOCATION: North Fort Myers
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 868 Moody Road
10f. ZIP CODE: ~~33935~~ 33903
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: [XX] 1 Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: [XX] 1975-1981
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES [XX] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): 4 Years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PILOT Helicopter ~~Pielet~~
16b. KIND OF BUSINESS/INDUSTRY: Pest Control
17. FATHER'S NAME (First, Middle, Last): Joel Lee Knight, Jr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna ~~Josler~~ Lee Kesler
19a. INFORMANT'S NAME (Type/Print): Joel Lee Knight, Jr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2 Box 49-K Bonifay, Florida 32425
20a. METHOD OF DISPOSITION: [XX] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): East Mount Zion Cemetery
20c. LOCATION — City or Town, State: Holmes Co. FL
21. SIGNATURE OF FUNERAL SERVICE LICENSEE:
22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd.Towson,MD21204

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple Injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] 1 YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [XX] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? [XX] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence [XX] 6 Other (Specify) scene
27. MANNER OF DEATH: 1 [ ] Natural [XX] 2 Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 5-22-89
28b. TIME OF INJURY: 7:28AM
28c. INJURY AT WORK? [XX] 1 YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: Pilot of helicopter that hit power lines and crashed
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): hill
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 51 S. of Cumberland-Old Town Road, Allegany County,MD
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 5-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC
31. DATE FILED (Month, Day, Year): MAY 26 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Goodin

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12888
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

N

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BENJAMIN FRANKLIN LASHLEY SR. | | | | | 2. DATE OF DEATH: MONTH 5-19-89 DAY YEAR | 3. TIME OF DEATH: 3:00 P M |
| 4. SOCIAL SECURITY NUMBER: 214070752 | 5. SEX: XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-23-05 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): MORAN MANOR NURSING HOME 200 CLAYTON AVE | 9b. CITY, TOWN OR LOCATION OF DEATH: WESTERNPORT MD | 9c. COUNTY OF DEATH: ALLEGANY | | | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ALLEGANY | 10c. CITY, TOWN OR LOCATION: CUMBERLAND | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 120 NEW HAMPSHIRE AVENUE | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): KELLY SPRINGFIELD TIRE CO | 16b. KIND OF BUSINESS/INDUSTRY: TIRE | |
| 17. FATHER'S NAME (First, Middle, Last): MILTON D. LASHLEY | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BROSIA MAY RICE | | |
| 19a. INFORMANT'S NAME (Type/Print): BENJAMIN F. LASHLEY JR. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2295 SHADES LANE CUMBERLAND MARYLAND 21502 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK | 20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt | 22. NAME AND ADDRESS OF FACILITY: 404 DECATUR STREET CUMBERLAND MARYLAND | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Septicemia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c. General Debility
DUE TO (OR AS A CONSEQUENCE OF):
d. Cancer of Lung with Brain Metastases

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jesus H Tan | 29c. LICENSE NUMBER: D21244 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR JESUS TAN FROSTBURG PLAZA FROSTBURG, MD 21532 | | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12889 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ada B Morgan | | | | 2. DATE OF DEATH (Month, Day, Year): 5 20 89 | 3. TIME OF DEATH: 2:35 p M |
| 4. SOCIAL SECURITY NUMBER: 218-48-7638 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12 28 99 | 8. BIRTHPLACE (State or Foreign Country): W. VA |
| 9a. FACILITY NAME (If not institution, give street and number): Frostburg, Community Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg, | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 730 Hill Top Drive | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): John H. Fultz | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Janie Snyder | |
| 19a. INFORMANT'S NAME (Type/Print): Clarence L. Morgan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 324 Sunset Drive LaVale, Maryland 21502 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park | 20c. LOCATION — City or Town, State: Cumberland, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas L. Hafer | | 22. NAME AND ADDRESS OF FACILITY: Hafer Funeral Home 1302 National Hwy LaVale, MD 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Stroke c left hemiplegia | |
| | DUE TO (OR AS A CONSEQUENCE OF): Cerebral hemorrhage into the Pons. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonitis Parkinsons Disease
Congestive Failure
Senile Dementia due to past Strokes.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S.L. Sandhir MD attending Physician | 29c. LICENSE NUMBER: D14464 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/22/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. S.L. Sandhir 48 Tarn Terrace, Frostburg MD | | | |
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall | | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12890
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NORMA IZOLA MICHAEL | | | | 2. DATE OF DEATH: MONTH 5 DAY 11 YEAR 89 | 3. TIME OF DEATH: 9:10P M |
| 4. SOCIAL SECURITY NUMBER: 236146022 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Aug.28,1912 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: WV | 10b. COUNTY: Hampshire | 10c. CITY, TOWN OR LOCATION: Romney | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 196 School Street | | 10f. ZIP CODE: 26757 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner and Manager | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last): William Thurman Moreland | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alverta Ann Shingleton | |
| 19a. INFORMANT'S NAME (Type/Print): Raymond L. Michael | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 196 School Street, Romney, WV 26757 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ebenezer Cemetery | 20c. LOCATION — City or Town, State: Romney WV | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark Rolfe | 22. NAME AND ADDRESS OF FACILITY: Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ca of the lung with pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Gud septic shock | 4 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Alzheimers disease | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John Mehanna M.D. | 29c. LICENSE NUMBER: D-17526 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-12-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR J MEHANNA 909 B SETON DR CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 16 1989 | 32. REGISTRAR'S SIGNATURE: |

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12891
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

N

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HAROLD RUSSELL MILLER | | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 17 / 89 | 3. TIME OF DEATH: 7:45 A M |
| 4. SOCIAL SECURITY NUMBER: 218 16 4871 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 08-22-1922 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND, MD | | 9c. COUNTY OF DEATH: ALLEGANY COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cresaptown | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 14611 Winchester Road | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): former employee | 16b. KIND OF BUSINESS/INDUSTRY: Hospital and Textile | |
| 17. FATHER'S NAME (First, Middle, Last): Jacob H. Miller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora C. Bittinger | |
| 19a. INFORMANT'S NAME (Type/Print): Wilda O. Miller | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14611 Winchester Road, Cresaptown, MD 21502 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park | 20c. LOCATION — City or Town, State: Cumberland, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home 108 Virginia Avenue, Cumberland, MD 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Chronic Lymphocytic Leukemia Stage V.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Anemia + Thrombocytopenia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Depressive personality

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John Mehanna M.D. | 29c. LICENSE NUMBER: D-17526 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. JOHN MEHANNA, 909-B SETON DRIVE, CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 18 1989 | 32. REGISTRAR'S SIGNATURE |

5

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12892
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HOMER VARNER MARTZ | | | 2. DATE OF DEATH (Month, Day, Year): May 8, 1989 | 3. TIME OF DEATH: 12:50 A M |
| 4. SOCIAL SECURITY NUMBER: 220-10-7520 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JAN 16 1912 | 8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ALLEGANY | 10c. CITY, TOWN OR LOCATION: CUMBERLAND | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: RFD# 3 BOX# 308 BEDFORD ROAD | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: usa |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW11 | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HEAVY EQUIPMENT OPERATOR | 16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION | |
| 17. FATHER'S NAME (First, Middle, Last): LINCOLN ABRAHAM MARTZ | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LAURA BERGER | |
| 19a. INFORMANT'S NAME (Type/Print): EVELYN MARTZ RFD# 3 | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOX# 308 BEDFORD ROAD CUMBERLAND MARYLAND 21502 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. LEBANON CEMETERY | 20c. LOCATION — City or Town, State: GLENCOE, PENNA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt | | 22. NAME AND ADDRESS OF FACILITY: SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Advanced Lymphoma of the testes | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Qamar Zaman Memorial Hospital Medical Bldg. Cumberland, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 09 1989 | 32. REGISTRAR'S SIGNATURE: Lisa Davidson Randall |

DHMH-16 Rev 1/89

17

89 12892

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12893
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): VIRGINIA M. MCMILLAN

**2. DATE OF DEATH** (Month, Day, Year): May 5, 1989

**3. TIME OF DEATH**: 5:04 A M

**4. SOCIAL SECURITY NUMBER**: 214-28-7193

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 72 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 01-10-1917

**8. BIRTHPLACE** (State or Foreign Country): MD

**9a. FACILITY NAME** (If not institution, give street and number): Memorial Hospital Medical Center

**9b. CITY, TOWN OR LOCATION OF DEATH**: Cumberland

**9c. COUNTY OF DEATH**: Allegany

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: Allegany

**10c. CITY, TOWN OR LOCATION**: Cumberland

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 11 Putman Street

**10f. ZIP CODE**: 21502

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: X

**14. RACE — American Indian, Black, White, etc.**
Specify: white

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 8 +):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): housewife

**16b. KIND OF BUSINESS/INDUSTRY**: own home

**17. FATHER'S NAME** (First, Middle, Last): William Cornelius

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Vergie Miller

**19a. INFORMANT'S NAME** (Type/Print): Mr. William T. McMillan

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Putman Street, Cumberland, MD 21502

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): St. Marys Cemetery

**20c. LOCATION — City or Town, State**: Cumberland, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ James F Scarpelli

**22. NAME AND ADDRESS OF FACILITY**: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** →
a. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: R T Barrera

**29c. LICENSE NUMBER**

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5-8-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Dr. Robustiano Barrera, Memorial Hospital Medical Building, Cumberland, MD. 21502

**31. DATE FILED** (Month, Day, Year): MAY 09 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12894

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Don R. Miller | | | | | 2. DATE OF DEATH (Month, Day, Year): 05 08 1989 | 3. TIME OF DEATH: 2300 M |
| 4. SOCIAL SECURITY NUMBER: 200 32 5757 | 5. SEX: X M 2 F | 6. AGE (In yrs. last birthday): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/11/1935 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: FRostburg, MD | | | 9c. COUNTY OF DEATH: Allegany | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: PA | 10b. COUNTY: Somerset | 10c. CITY, TOWN OR LOCATION: Springs, PA | 10d. INSIDE CITY LIMITS? X YES 2 X NO |
| 10e. STREET AND NUMBER: Star Route | 10f. ZIP CODE: 15562 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1957 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 6+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | 16b. KIND OF BUSINESS/INDUSTRY: Farming | |
| 17. FATHER'S NAME (First, Middle, Last): Leonard L Miller | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma E Wagner | | |
| 19a. INFORMANT'S NAME (Type/Print): Janet K Hillegas Miller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Rte. Springs, Pa. 15562 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Salisbury Cemetery | 20c. LOCATION — City or Town, State: Salisbury, Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Garfield F. Thomas | 22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 101 Grant St Salisbury, Pa 15558 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Intra Cranial metastatic Disease | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Malignant melanoma. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S L Sandhir MD | 29c. LICENSE NUMBER: D 14464 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. S. Lal Sandhir 48 Tarn Terrace FRostburg, MD 21532 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Denison-Landers | |

15

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12895
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GLORIA JEAN MITCHELL | | | 2. DATE OF DEATH (Month, Day, Year): MAY 3, 1989 | 3. TIME OF DEATH: 1:20A M |
| 4. SOCIAL SECURITY NUMBER: 227-82-8991 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 43 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 7, 1945 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: West Virginia | 10b. COUNTY: Mineral | 10c. CITY, TOWN OR LOCATION: Ridgeley | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt. 1 Box 552B | | 10f. ZIP CODE: 26753 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Merchandiser | 16b. KIND OF BUSINESS/INDUSTRY: Drug X | |
| 17. FATHER'S NAME (First, Middle, Last): Aaron S. Woodell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma Kennedy | |
| 19a. INFORMANT'S NAME (Type/Print): James Mitchell | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 above | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens | 20c. LOCATION — City or Town, State: Cumberland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. Mark Sigg | | 22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Hm. 202 Greene St. Cumb., MD 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Advanced Metastatic Breast Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D23371 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. O. Zaman Memorial Hospital Medical Building Cumberland, Maryland 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 09 1989 | 32. REGISTRAR'S SIGNATURE |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12896

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Alan CHESTER MILLER | | | 2. DATE OF DEATH (Month, Day, Year): 05 04 89 | 3. TIME OF DEATH: 2202 P M |
| 4. SOCIAL SECURITY NUMBER: 213 44 1845 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6, 23, 1944 | 8. BIRTHPLACE (State or Foreign Country): Maryland |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ALLEGANY | 10c. CITY, TOWN OR LOCATION: CUMBERLAND | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 16 4TH STREET | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [XX] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Md. Natl. Guard | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: No | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Firefighter | 16b. KIND OF BUSINESS/INDUSTRY: City of Cumberland Fire Dept. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Marcus R. Miller | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Ruth M. Ruhl |
| 19a. INFORMANT'S NAME (Type/Print): James R. Miller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Rt 2 Box 71 New Creek, W.Va. 26742 |

| | | |
|---|---|---|
| 20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Potomac Mem. Gardens | 20c. LOCATION — City or Town, State: Keyser, W.Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allen W. Rotruck | 22. NAME AND ADDRESS OF FACILITY: Rotruck Funeral Home 85 S.Main St. Keyser, W.Va. 26726 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. BRAIN INJURY – INTRA ABDOMINAL HEMORRHAGE DUE TO MOTORCYCLE ACCIDENT | 1 HOUR |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [XX] YES 2 [ ] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28e. DATE OF INJURY (Month, Day, Year): 5-5-89 | 28b. TIME OF INJURY: 8:45 PM | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: LOSS OF CONTROL SINGLE VEHICLE ACCIDENT |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): ROAD | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): RT 48 MILE 38, EASTBOUND |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Giovanni Mastrangelo DEPUTY MED. EXAMINER | 29c. LICENSE NUMBER: D07098 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GIOVANNI MASTRANGELO 900 SETON DR. CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12897

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA LEE MC DONALD
2. DATE OF DEATH (Month, Day, Year): May 13, 1989
3. TIME OF DEATH: 10:00 A.M
4. SOCIAL SECURITY NUMBER: 236-20-9349
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 25, 1919
8. BIRTHPLACE (State or Foreign Country): Burlington, W.Va.
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

**RESIDENCE OF DECEDENT**

10a. STATE: Md.
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Winfred and Williams St.
10f. ZIP CODE: 26726
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress
16b. KIND OF BUSINESS/INDUSTRY: Ladies Garment Factory
17. FATHER'S NAME (First, Middle, Last): Olen -- McDonald
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena B. Whipp
19a. INFORMANT'S NAME (Type/Print): Herself (Funeral Home Records
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 S. Mineral Street, Keyser, W.Va. 26726
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ebenezer Cemetery
20c. LOCATION — City or Town, State: Romney, W. Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold W. McCauley
22. NAME AND ADDRESS OF FACILITY: 111 S. Mineral Street, Keyser, W. Va. 26726

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | respiratory failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | aspiration pneumonia | 3days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: chronic Schizophrenia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Sagin MD
29c. LICENSE NUMBER: D35481
29d. DATE SIGNED (Month, Day, Year): ▶ 5/13/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Mark Sagin, Memorial Hospital, Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): MAY 17 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landacre

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12898
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): COSBY KENNETH MORRIS | | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 27 / 89 | 3. TIME OF DEATH: 5:20 AM |
| 4. SOCIAL SECURITY NUMBER: 212 30 6242 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-2-32 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND, MD | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. W.Va. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Port Ashby, West Virginia 26719 | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Star Rt.#1 Box 19B Port Ashby, W.Va. | | 10f. ZIP CODE: 26719 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Crane Oper. | 16b. KIND OF BUSINESS/INDUSTRY: Bethelem Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Edgar Morris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Guernie Shiflett | |
| 19a. INFORMANT'S NAME (Type/Print): Trudy M. Morris | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Star Rt.#1 Box 19B Port Ashby, West Va. 26719 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crestlawn Cemetery | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home, Inc 2134 Willow Spring Rd. Dundalk, Md. 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebral Metastes
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic Carcinoma of Esophagus
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Post Esophagectomy for Carcinoma + Radiation Therapy

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO — PARTIAL | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 6 [ ] Residence 6 [X] Other (Specify) Hospital | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Nicholas Ciarletta MD | 29c. LICENSE NUMBER: D [illegible] | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
PAUL LIVENGOOD, M.D., BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12899 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARJORIE ELLEN NAVE | | | 2. DATE OF DEATH (Month, Day, Year): May 18, 1989 | 3. TIME OF DEATH: 5:00 P M |
| 4. SOCIAL SECURITY NUMBER: 215-20-5386 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): AUGUST 20 1924 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ALLEGANY | 10c. CITY, TOWN OR LOCATION: CUMBERLAND MARYLAND | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 518 CONRAD AVENUE | | 10f. ZIP CODE: 21502 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: HOUSEWIFE | |
| 17. FATHER'S NAME (First, Middle, Last): MILLARD R. SMELTZER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GERTRUDE BARTIK | |
| 19a. INFORMANT'S NAME (Type/Print): ROBERT E. NAVE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 CONRAD AVENUE CUMBERLAND, MARYLAND 21502 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SUNSET MEMORIAL PARK | 20c. LOCATION — City or Town, State: CUMBERLAND MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt | | 22. NAME AND ADDRESS OF FACILITY: 404 DECATUR STREET CUMBERLAND, MARYLAND 21502 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiorespiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Cerebrovascular accident — 2 month
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William Quinn MD | 29c. LICENSE NUMBER: D 25466 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Terry Williams, Medical Building, Cumberland, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Judith Henderson-Hendrickson |

DHMH-16 Rev 1/89

89 12900

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALBERT JOSEPH NOONAN | | | 2. DATE OF DEATH (Month, Day, Year): 05 13 89 | 3. TIME OF DEATH: 21:10pm M |
| 4. SOCIAL SECURITY NUMBER: 214-147-959 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/14/1916 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Frostburg | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 68 Meshach Frost Village | 10f. ZIP CODE: 21532 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Driver | 16b. KIND OF BUSINESS/INDUSTRY: Cab Company | |
| 17. FATHER'S NAME (First, Middle, Last): Albert Joseph Noonan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Marie Bollinger | |
| 19a. INFORMANT'S NAME (Type/Print): Beulah C. Noonan | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 68 Meshach Frost Village, Frostburg, Md. 21532 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park | 20c. LOCATION — City or Town, State: Frostburg, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Durst | 22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, of complications thet caused the death. Do not enter the mode of dying, auch ea cerdiec or respiratory arreat, ahock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. SHOCK.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. RUPTURED ANASTOMOTIC ANEURYSM Right femora ARTERY

DUE TO (OR AS A CONSEQUENCE OF):

c. AORTO FEMORAL GRAFT

DUE TO (OR AS A CONSEQUENCE OF):

d. ABDOMINAL ANEURYSM

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

MULTIINFARCT, CEREBROVASCULAR ACCIDENT. Seizure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH (Check only one): 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S Chang M.D. | 29c. LICENSE NUMBER: D25638 | 29d. DATE SIGNED (Month, Day, Year): 5/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. SATURNINA CHANG FROSTBURG PLAZA FROSTBURG, MD. 21532

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 16 1989 | 32. REGISTRAR'S SIGNATURE: Deborah Gardner-Randall |

DHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12901
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HAZEL L. OLIVER | | | 2. DATE OF DEATH (Month, Day, Year): May 3, 1989 | 3. TIME OF DEATH: 10:50P M |
| 4. SOCIAL SECURITY NUMBER: 232-96-3047 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 03-05-1903 | 8. BIRTHPLACE (State or Foreign Country): WV |
| 9a. FACILITY NAME (If not institution, give street and number): MEMORIAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, | | 9c. COUNTY OF DEATH: Allegany |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: LaVale | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 10 Roger Way | | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife | | 16b. KIND OF BUSINESS/INDUSTRY: own home |
| 17. FATHER'S NAME (First, Middle, Last): Richard Stewart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Zelma Stewart | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert C. Oliver | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): LaVale, MD 21502 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Cemetery | | 20c. LOCATION — City or Town, State: Burton, WV |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home 108 Virginia Avenue, Cumberland, MD 21502 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiac Dysrhythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D12779 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Guy Fiscus Memorial Hospital Medical Building Cumberland, Md. 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 08 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 1290

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12902 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELSIE CLARA ORNDORFF
2. DATE OF DEATH (Month, Day, Year): May 7, 1989
3. TIME OF DEATH: 8:36 AM M
4. SOCIAL SECURITY NUMBER: 220-07-6240
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 94 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 22, 1895
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 847 Mt. Royal Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 847 Mt. Royal Avenue
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): George H. Wilhelm
18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara E. Troutman
19a. INFORMANT'S NAME (Type/Print): Phyllis Leasure
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 847 Mt. Royal Ave., CUmberland, MD 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cooks Mills Cemetery
20c. LOCATION — City or Town, State: Cooks Mills, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wendy D. Upchurch
22. NAME AND ADDRESS OF FACILITY: George-Upchurch FUneral Home, P.A. 202 Greene St., Cumberland, MD 21502

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. ARTERIOSCLEROTIC HEART DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SICK SINUS SYNDROME
SENILE DEMENTIA
OSTEOARTHRITIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: H Sidhu M.D
29c. LICENSE NUMBER: D 26907
29d. DATE SIGNED (Month, Day, Year): ▶ 5/7/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harjit S. Sidhu, M.D. 925 Bishop Walsh Road, Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): MAY 09 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kimmell

DHMH-18 Rev 1/89

SOGSI 68

89 12903

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES RUSSELL PRINKEY | | | | 2. DATE OF DEATH (Month, Day, Year): 05/20/989 | 3. TIME OF DEATH: 4:05A M |
| 4. SOCIAL SECURITY NUMBER: 162142317 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Sept. 20, 1907 | 8. BIRTHPLACE (State or Foreign Country): Penna |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | | |
|---|---|---|---|---|
| 10a. STATE: Penna. | 10b. COUNTY: BEdford | 10c. CITY, TOWN OR LOCATION: Hyndman | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: Rt#1 Box 61 | | 10f. ZIP CODE: 15545 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Walter Prinkey | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Ritenour | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Irene Prinkey | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD#1 Box 61 Hyndman, Pa. 15545 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Normalville Cemetery | 20c. LOCATION — City or Town, State: Normalville, Penna. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert C. Adams | 22. NAME AND ADDRESS OF FACILITY: Silcox-Merritt Funeral Ser. 404 Decatur St. Cumberland, Md. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOMYOPATHY, ISCHEMIC | 1 YR. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CORONARY ARTERY DISEASE | 20 YRS. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MAJOR DEPRESSION

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURRED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | | 29c. LICENSE NUMBER: D 34812 | 29d. DATE SIGNED (Month, Day, Year): 5/22/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. EUGENE NALLIN PO BOX 606 HYNDMAN, PA 15545 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Gladys Davidson-Randall | | |

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DHMN-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12904
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM Claude PARK
2. DATE OF DEATH (Month, Day, Year): MAY 2, 1989
3. TIME OF DEATH: 11:25A M
4. SOCIAL SECURITY NUMBER: 219-03-8238
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 67 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 31, 1921
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany
RESIDENCE OF DECEDENT
10a. STATE: MD
10b. COUNTY: Garrett
10c. CITY, TOWN OR LOCATION: Swanton
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt. 1, Box 142-E
10f. ZIP CODE: 21561
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Operating Engineer
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Thomas ----- Park
18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle ----- Sell
19a. INFORMANT'S NAME (Type/Print): Saretha H. Park
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 142-E, Swanton, Maryland 21561
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrett Co. Memorial Gardens
20c. LOCATION — City or Town, State: Oakland, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bradley A. Stewart
22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home, 32 S. Second St., Oakland, MD 21550

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CA-LUNG — 4 years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. EMPHYSEMA

DUE TO (OR AS A CONSEQUENCE OF):

c. CHRONIC BRONCHITIS

DUE TO (OR AS A CONSEQUENCE OF):

d. COR PULMONALE WITH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA
RESPIRATORY INSUFFICIENCY

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James M Raver
29c. LICENSE NUMBER: D18764
29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. JAMES RAVER MEMORIAL HOSPITAL CUMBERLAND, MARYLAND 21502
31. DATE FILED (Month, Day, Year): MAY 4 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Mendell

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OHMH-16 Rev 1/89

89 1290

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12905 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ulysses E Phennicie | | | 2. DATE OF DEATH MONTH 4 DAY 19 YEAR 89 | 3. TIME OF DEATH 9:30 AM |
| 4. SOCIAL SECURITY NUMBER: 206-07-3001 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5-9-21 | 8. BIRTHPLACE (State or Foreign Country): Penna. |
| 9a. FACILITY NAME (If not institution, give street and number): Wooded Area | | 9b. CITY, TOWN OR LOCATION OF DEATH: La Vale | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Frostburg | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 22 Hope Rd. | | 10f. ZIP CODE: 21532 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: W |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor State Hwy | 16b. KIND OF BUSINESS/INDUSTRY: State Roads | |
| 17. FATHER'S NAME (First, Middle, Last): Dewey Phennicie | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Miller | |
| 19a. INFORMANT'S NAME (Type/Print): Elvie R. Phennicie | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 Hope Road Frostburg, Maryland 21532 | |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Carmel Lutheran Cemetery | 20c. LOCATION — City or Town, State: White Oaks, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. A. S. C. V. D. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): Wooded Area |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Francisco Reyes | 29c. LICENSE NUMBER: D19316 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Francisco Reyes 1112 Bishop Walsh Drive, Cumberland, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 24 1989 | 32. REGISTRAR'S SIGNATURE: Lidia Davidson-Randall |

DHMH-16 Rev 1/89

89 12905

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12906

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ARLENE MARIE PYLES | | | | | 2. DATE OF DEATH MONTH 5 DAY 2 YEAR 89 | 3. TIME OF DEATH 6:26P M |
| 4. SOCIAL SECURITY NUMBER: 473362439 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 55 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb 17, 1934 | 8. BIRTHPLACE (State or Foreign Country): Minn. |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND | | 9c. COUNTY OF DEATH: ALLEGANY COUNTY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: WV | 10b. COUNTY: Mineral | 10c. CITY, TOWN OR LOCATION: Keyser | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 24 Sharpless Street | | 10f. ZIP CODE: 26726 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Public Schools | |
| 17. FATHER'S NAME (First, Middle, Last): Leonard Paulson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Washkuhn | |
| 19a. INFORMANT'S NAME (Type/Print): Kathleen Ann Perry | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 71 Allegany St Keyser, WV 26726 | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Potomac Memorial Gardens | 20c. LOCATION — City or Town, State: Keyser, WV | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Craig Rotruck | | 22. NAME AND ADDRESS OF FACILITY: Rotruck Funeral Home 85 South Main Street Keyser, WV 26726 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart failura. List only one ceuse on eech lins.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. End Stage Metastatic Melanoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: DR G Wagoner MD | 29c. LICENSE NUMBER: D22181 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR G WAGONER 925 BISHOP WALSH RD CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Erickson-Rudasill |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12907

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Leo Robinette Jr. | | | 2. DATE OF DEATH (Month, Day, Year): 5 26 89 | 3. TIME OF DEATH: 12:24 aM |
| 4. SOCIAL SECURITY NUMBER: 217-84-3194 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (If yrs. last birthday): 24 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 21, 1964 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): P.O. Box 393 (bedroom) | | 9b. CITY, TOWN OR LOCATION OF DEATH: Midlothian | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Box 393 Midlothian | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Box 393 | 10f. ZIP CODE: 21543 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic | 16b. KIND OF BUSINESS/INDUSTRY: Coal Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Wm. Leo Robinette Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Carol Ann Yantz | |
| 19a. INFORMANT'S NAME (Type/Print): Vicky Rae Robinette | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 393, Midlothian, Md. 21543 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Cemetery | 20c. LOCATION — City or Town, State: Lonaconing, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James E McKenzie | | 22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Shotgun wound to chin
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 ☐ NO | HEAD ONLY |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 X Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5/25/89 | 28b. TIME OF INJURY: 11:20p M | 28c. INJURY AT WORK? 1 ☐ YES 2 X NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Subject shot self | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Midlothian, Md. P.O. Box 393 (bedroom) | |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. Allegany Co.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D., 111 Penn Street, Baltimore, Maryland 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12908

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DONALD L. ROBINETTE | | | 2. DATE OF DEATH (Month, Day, Year): May 3, 1989 | 3. TIME OF DEATH: 9:00 pM |
| 4. SOCIAL SECURITY NUMBER: 212-24-1402 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 13, 1927 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, MD 21502 | | 9c. COUNTY OF DEATH: Allegany |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Flintstone | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Rt 1 Box 208 | | 10f. ZIP CODE: 21530 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: Korean Conflict | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist, Journeyman | 16b. KIND OF BUSINESS/INDUSTRY: Kelly Springfield Tire | |
| 17. FATHER'S NAME (First, Middle, Last): Owen Robinette | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): Rosannah Robinette | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 above | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oddfellows Cemetery | 20c. LOCATION — City or Town, State: Flintstone, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. Mark Swiger | | 22. NAME AND ADDRESS OF FACILITY: George-Upchurch Funeral Home, 202 Greene St. Cumb., MD 21502 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Recurrent bladder CA. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H.C. Merrick | 29c. LICENSE NUMBER: D28910 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-4-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. H.C. Merrick Memorial Hospital Medical Building: Cumberland, MD 21502 | | |
| 31. DATE FILED (Month, Day, Year): MAY 09 1989 | 32. REGISTRAR'S SIGNATURE: Jackie Davidson-Kimble | |

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DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 or 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12909

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ALFRED | Simeon | ROSS | May 15, 1989 | 10:30 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-03-2025 | XX 1 ☐ M 2 ☐ F | 97 YRS. | | | 2/22/1892 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Allegany | Midland | 1 X YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Box 184 | 21542 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 1 ☐ YES XX NO | 1 ☐ YES 2 XX NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| n/a | | Retired Miner | Coal |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Lacy W. Ross | Mandana Miller |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Wilbur Ross | 116 Armstrong St. Frostburg, Md. 21532 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Oak Hill Cemetery | Lonaconing, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Boal-Warnick Funeral Home Lonaconing, Md, 21539 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CVA | 10 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Atherosclerotic Cerebrovascular dis | yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dehydration; electrolyte imbalance
malnutrition

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D 17565 | ▶ 5/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Anthony Bollino Frederick Street, Cumberland, MD. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 26 1989 | [signature] |

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89 12910

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAZEL MAE SAGAL
2. DATE OF DEATH (Month, Day, Year): 5-19-89
3. TIME OF DEATH: 2:50P M
4. SOCIAL SECURITY NUMBER: 215206444
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/7/24
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ALLEGANY
10c. CITY, TOWN OR LOCATION: FROSTBURG
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 159 WARNS LANE
10f. ZIP CODE: 21532
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS
16b. KIND OF BUSINESS/INDUSTRY: BLOUSE FACTORY
17. FATHER'S NAME (First, Middle, Last): JOSEPH HOUSE
18. MOTHER'S NAME (First, Middle, Maiden Surname): MADGE COOK
19a. INFORMANT'S NAME (Type/Print): GEORGE P. SAGAL, SR.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 159 WARNS LANE, FROSTBURG, MD 21532
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FROSTBURG MEMORIAL PARK
20c. LOCATION — City or Town, State: FROSTBURG
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marilou M. Sowers
22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME 60 WEST MAIN STREET FROSTBURG, MD 21532

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma Colon | 6 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: L.R. Miles JR MD VP/Med Affairs
29c. LICENSE NUMBER: D07004
29d. DATE SIGNED (Month, Day, Year): ▶ 5/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L.R. MILES, JR., M.D. DR S CHANG FROSTBURG PLAZA FROSTBURG, MD 21502
31. DATE FILED (Month, Day, Year): MAY 23 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12911

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MARTHA LEE SEE

**2. DATE OF DEATH** (Month / Day / Year): 5 / 8 / 89

**3. TIME OF DEATH**: 12:24 PM

**4. SOCIAL SECURITY NUMBER**: 234 40 3339

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 7 29 1927

**8. BIRTHPLACE** (State or Foreign Country): W.Va.

**9a. FACILITY NAME** (If not institution, give street and number): SACRED HEART HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: CUMBERLAND, MD

**9c. COUNTY OF DEATH**: ALLEGANY COUNTY

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: Mineral

**10c. CITY, TOWN OR LOCATION**: Keyser

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 14 Potomac Drive

**10f. ZIP CODE**: 26726

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECEDENT OF HISPANIC ORIGIN?** (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

**16b. KIND OF BUSINESS/INDUSTRY**: Home

**17. FATHER'S NAME** (First, Middle, Last): UNKNOWN

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Ada Liller

**19a. INFORMANT'S NAME** (Type/Print): William M. See

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 Potomac Drive Keyser, W.Va. 26726

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Potomac Mem. Gardens

**20c. LOCATION — City or Town, State**: Keyser, W.Va.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶ [signature]

**22. NAME AND ADDRESS OF FACILITY**: Rotruck Funeral Home
85 S.Main St. Keyser, W.Va. 26726

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Acute anterior wall M.I. c obstruction

DUE TO (OR AS A CONSEQUENCE OF): C.H.F. 2 to #1

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): Cardiogenic shock 2 to #1

c. DUE TO (OR AS A CONSEQUENCE OF): Complete A/V Block 2 to #1

d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Hypertension

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] MD

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year) ▶ 5-8-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)
DR. URIEL VELANDIA, 924 SETON DRIVE, CUMBERLAND, MD 21502

**31. DATE FILED** (Month, Day, Year): MAY 12 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Landeck

DHMH-18 Rev 1/89

3

89 12912

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VALLIE MARIE SCHMIDT | | | 2. DATE OF DEATH (Month, Day, Year): 5-19-89 | 3. TIME OF DEATH: 9:20P M |
| 4. SOCIAL SECURITY NUMBER: 219147409 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-17-1920 | 8. BIRTHPLACE (State or Foreign Country): Cumberland, MD |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland, Maryland | | 9c. COUNTY OF DEATH: ALLEGANY |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: 918 Maryland Avenue Cumberland, MD | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 918 Maryland Avenue | | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Allen Ernst | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisey Ernst | | |
| 19a. INFORMANT'S NAME (Type/Print): Raymond M. Schmidt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2051 Benner Street Philadelphia, PA 19134 | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State: Philadelphia, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Nicholas J. Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home 108 Virginia Avenue Cumberland, MD 21502 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma of breast. | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Thomas J. Devlin M.D. Thomas J. Devlin M.D. | D 21488 | ▶ 5-20-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR DONALD MANGER 55 JACKSON ST LONACONING MD 21539

| 31. DATE FILED (Month, Day, Year) | REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-12913

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | | | 3. TIME OF DEATH |
| Violet | | Saylor | 4 | 22 | 89 | 1040AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 199-30-5726 | 1 ☐ M 2 ☒ F | 73 YRS. | | | 10-01-1915 | Pa. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Cumberland Manor Apts 229Balt. | Ave Cumberland Md | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Allegany | Cumberland | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 229 Baltimore Ave Apt 205 | 21502 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Homemaker | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Edward Sheeler | Alice Thompson |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Kathleen Shockey | 405 Homer St. Cumberland, Md. 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Union Cemetery | Meyersdale, Pa. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ William R. Price II | Price Funeral Home 325 Main St., Meyersdale, Pa. 15552 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-pulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic cardiovascular heart disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peptic ulcer

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul Snow | D09157 | ▶ 4/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Paul Snow, M.D. 124 W. 3rd St. Cumberland Md 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 26 1989 | Julia Davidson-Rondeau |

DHMH-18 Rev 1/89

89 12914

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAYMOND GEORGE SHAFFER | | | 2. DATE OF DEATH (Month, Day, Year): MAY 3, 1989 | 3. TIME OF DEATH: 5:20A M |
| 4. SOCIAL SECURITY NUMBER: 217-09-1102 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 03/16/18 | 8. BIRTHPLACE (State or Foreign Country): NY |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: Allegany | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: PA | 10b. COUNTY: BEDFORD | 10c. CITY, TOWN OR LOCATION: HYNDMAN | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: R D 1 | 10f. ZIP CODE: 15545 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | 16b. KIND OF BUSINESS/INDUSTRY: RAILROAD | |
| 17. FATHER'S NAME (First, Middle, Last): RALPH E. SHAFFER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HARRIET E. SMITH | | |
| 19a. INFORMANT'S NAME (Type/Print): DARLENE N. LOWERY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P O BOX 365, HYNDMAN, PA 15545 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HYNDMAN CEMETERY | 20c. LOCATION — City or Town, State: HYNDMAN, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harvey H. Zeigler | 22. NAME AND ADDRESS OF FACILITY: HARVEY H. ZEIGEER F. H. CLARENCE STREET, HYNDMAN, PA 15545 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Chronic Pneumonia | yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Respiratory Failure | yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D 12779 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Guy Fiscus Memorial Hospital Medical Building Cumberland, Maryland 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 08 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12915

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LENA EVA STEPHENS | | | 2. DATE OF DEATH: MONTH 04 DAY 26 YEAR 89 | 3. TIME OF DEATH: 22:45pm M |
| 4. SOCIAL SECURITY NUMBER: 233181620 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country): W. Va |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Western Port | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 322 Greene St | | 10f. ZIP CODE: 21562 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarlo Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic | | 16b. KIND OF BUSINESS/INDUSTRY: Housewife |
| 17. FATHER'S NAME (First, Middle, Last): Samuel Studenwalt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Hutman | | |
| 19a. INFORMANT'S NAME (Type/Print): Donald Stephens | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 322 Greene St Western Port Md | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Potomac Memorial Garden | | 20c. LOCATION — City or Town, State: Keyser, W. Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Valerie Wampler | | 22. NAME AND ADDRESS OF FACILITY: Boal-Warnick Funeral Home Westernport Md | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute anterior wall myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. post cerebral vascular accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DSDP . Cyanosis | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | 015463 | 4/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): DR. SHIN KIM 90 MAIN ST. WESTERNPORT MD. 21562

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 28 1989 | Julia Davidson-Randall |

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DHMH-16 Rev 1/89

Kingsmen Memorial Post-Mortem Thesis, 1964

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12916

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): AUSTIN DELBERT TICHNELL | | | | 2. DATE OF DEATH (Month, Day, Year): 5-18-89 | 3. TIME OF DEATH: 12:20P M |
| 4. SOCIAL SECURITY NUMBER: 215164330 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Sept. 8, 1921 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Garrett | 10c. CITY, TOWN OR LOCATION: Bloomington | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Bloomington | 10f. ZIP CODE: 21523 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW2 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/a; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Westvaco | 16b. KIND OF BUSINESS/INDUSTRY: Paper | |
| 17. FATHER'S NAME (First, Middle, Last): Abner Tichnell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Iva Paugh | |
| 19a. INFORMANT'S NAME (Type/Print): Ruth Tichnell | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Bloomington, Md. 21523 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bloomington Cemetery | 20c. LOCATION — City or Town, State: Bloomington Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ T. Maynard Boal Jr. | | 22. NAME AND ADDRESS OF FACILITY: Boal-Warnick F. Home Westernport, Md. 21562 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma Colon | 6 mos. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: L.R. Miles Jr MD VP/Med affairs | 29c. LICENSE NUMBER: D07004 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/22/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR T CHAPPELL 912 SETON DR CUMBERLAND, MD 21502 L.R. MILES, JR., M.D. | | | |
| 31. DATE FILED (Month, Day, Year): MAY 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasso | | |

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12917 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

2

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERNADETTE R. TROST
2. DATE OF DEATH (Month, Day, Year): May 21, 1989
3. TIME OF DEATH: 3:45 P M
4. SOCIAL SECURITY NUMBER: 220-10-7346
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct 31, 1903
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: ALLEGANY
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 712 MARYLAND AVE
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): George Fleckenstein
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jane Brant
19a. INFORMANT'S NAME (Type/Print): Mary Jane Hollen
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1201 E. First St, Cumberland, MD 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park
20c. LOCATION — City or Town, State: Cumberland MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William F. Kight
22. NAME AND ADDRESS OF FACILITY: Kight Funeral Home 301 Bill Decatur St, Cumberland MD 21502

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gangrene feet, CVA,
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHF, Sepsis.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: K R [illegible]
29c. LICENSE NUMBER: D 31579
29d. DATE SIGNED (Month, Day, Year): 5/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. N. A. Ranjithan Memorial Hospital Medical Bldg. Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): MAY 23 1989
32. REGISTRAR'S SIGNATURE: Julia [illegible]

DHMH-18 Rev 1/89

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1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12918

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|
| EVA K Tully | 5 / 19 / 89 | 4:30 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-12-8931 | 1 ☐ M 2 ☒ F | 74 YRS. | | | 11-11-14 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Moran Manor | Westernport Md | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | Baltimore | Randallstown | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 9005 Meadow Heights (Formerly Of) | 21133 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 0 | Clerk | Social Security Adm. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Charles Watson Clark | Christine Agnes Bowen |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Wm. Clark | Dogwood Flat, Barton, Md. 21521 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mausoleum | Lorraine Park Cem. & Mausoleum | Baltimore, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James E McKenzie | Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory srrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Chronic Renal Failure | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic pyleneephritis, Hypertension | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Small Cell Carcinoma right Lung

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERREO TO MEOICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

**29a. CERTIFIER** (Check only one)
1 ☒ **CERTIFYING PHYSICIAN:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **MEDICAL EXAMINER:** On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Thomas J. Devlin MD | D21488 | ▶ 5-20-89 |

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)
Thomas J. Devlin MD., 55 Jackson St., Lonaconing, Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 23 1989 | Julia Dawson Landeck |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12920
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page-6 may be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page-6 may be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

Sent Copies 5/25/89 KW

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eileen E. Worthman | | | 2. DATE OF DEATH: MONTH May DAY 4 YEAR 89 | 3. TIME OF DEATH: 4:48 p M | |
| 4. SOCIAL SECURITY NUMBER: 040-32-6025 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4/30/1938 | 8. BIRTHPLACE (State or Foreign Country): Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number): Washington Co. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown | | 9c. COUNTY OF DEATH: Washington | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Pa. | 10b. COUNTY: Franklin | 10c. CITY, TOWN OR LOCATION: Greencastle | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 14232 Molly Pitcher Hwy. | | 10f. ZIP CODE: 17225 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+) | | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Domestic | |
| 17. FATHER'S NAME (First, Middle, Last): John L. Kelley | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amelia Renzkie | | | |
| 19a. INFORMANT'S NAME (Type/Print): George E. Worthman Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14232 Molly Pitcher Hwy. Greencastle Pa. 17225 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawns Memorial Gardens | | 20c. LOCATION — City or Town, State: Chambersburg Pa. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. Martin Zimmerman Jr | | 22. NAME AND ADDRESS OF FACILITY: Zimmerman & SOn Funeral Home Greencastle, Pa. | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolism

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. OUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Metastatic Breast Carcinoma

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Signature | D21457 | ▶ 5/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABDUL WAHEED, MD - 1610 Oak Hill Ave. Hagerstown MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 0 9 1989 | Signature |

DHMH-16 Rev 1/89

89 1250

Items 23a thu 28f per M.E. FilmG653 7/25/89cg

89 12921

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Todd Erik Wolf | | | 2. DATE OF DEATH (Month, Day, Year): 5-1-89 | 3. TIME OF DEATH: 6:20PM M |
| 4. SOCIAL SECURITY NUMBER: 218-94-0316 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 23 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/28/65 | 8. BIRTHPLACE (State or Foreign Country): Washington,D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 22 East Main Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg | | 9c. COUNTY OF DEATH: Allegany County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Rockville | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 17016 Freedom Way | | 10f. ZIP CODE: 20853 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: [X] 1 Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES [X] 2 NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Library | 16b. KIND OF BUSINESS/INDUSTRY: Geographer |
| 17. FATHER'S NAME (First, Middle, Last): Leslie Wolf | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley Smith | |
| 19a. INFORMANT'S NAME (Type/Print): Leslie Wolf (Father) | | 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17016 Freedom Way; Rockville, Md. 20853 | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King David Memorial Garden | 20c. LOCATION — City or Town, State: Falls Church, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Methyl alcohol intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] 1 YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] 1 YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] 1 YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) friends apartment | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation [X] 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): Unknown | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Unknown | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Apartment | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 22 East Main St. Frostburg, Allegany Co.Md. | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 0 9 1989 | 32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall |

DHMH-16 Rev 1/89

89 1291

89 12922

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

2

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Floyd R. Yost | | | 2. DATE OF DEATH (Month, Day, Year): 05 15 1989 | 3. TIME OF DEATH: 4;55 a M |
| 4. SOCIAL SECURITY NUMBER: 214 05 6724 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10/22/1908 | 8. BIRTHPLACE (State or Foreign Country): W.Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg, MD 21532 | | 9c. COUNTY OF DEATH: Allegany |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Frostburg | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 100 Honeysuckle Lane | | 10f. ZIP CODE: 21532 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: Contracting Co. | | |
| 17. FATHER'S NAME (First, Middle, Last): George Yost | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Waugh | | |
| 19a. INFORMANT'S NAME (Type/Print): John P. Horn | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 57 Frost Ave., Frostburg, Md. 21532 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park | 20c. LOCATION — City or Town, State: Cumberland, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John R. Durst | | 22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic Obstructive Pulm. Disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Acute Septal Myocardial Ischemia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Chang H. Oh MD | D24954 | ▶ May 16 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Oh, Chang H., MD 48 Tarn Terrace Frostburg, MD 21532

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 17 1989 | |

DHMH-18 Rev 1/89

89 1252

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12923 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry Carl Anderson
2. DATE OF DEATH: MONTH 5 DAY 8 YEAR 89
3. TIME OF DEATH: 6 39 AM/M
4. SOCIAL SECURITY NUMBER: 288-09-3636
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 91 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1-30-1898
8. BIRTHPLACE (State or Foreign Country): OHIO

9a. FACILITY NAME (If not institution, give street and number): 939 Tidewater Grove Ct.
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 939 Tidewater Grove Ct
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES ?
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) ? College (1-4 or 5+) ? years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CPA-Comptroller
16b. KIND OF BUSINESS/INDUSTRY: Yale Lock Co.

17. FATHER'S NAME (First, Middle, Last): August Anderson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hannah Carlson

19a. INFORMANT'S NAME (Type/Print): Dorothy C. Anderson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 939 Tidewater Grove Ct. Annapolis, MD 21401

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake Park Cemetery
20c. LOCATION — City or Town, State: Youngstown, Ohio

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey S. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel, Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Prostate — 4yrs
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A AM/M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO N/A
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D5?1
29d. DATE SIGNED (Month, Day, Year): ▶ 5/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr Robert O. Bieri 51 Franklin st. Annapolis Md 21401

31. DATE FILED (Month, Day, Year): 5-10-89 MAY 09 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 1253

89 12924

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES (NMN) ACOSTA | | | | 2. DATE OF DEATH (Month, Day, Year): May 22, 1989 | 3. TIME OF DEATH: 830 PM M |
| 4. SOCIAL SECURITY NUMBER: 220.09.6097 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): April 25, 1911 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 411 Rogers Avenue | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+): NA | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist (Ret) | 16b. KIND OF BUSINESS/INDUSTRY: Railroad | |
| 17. FATHER'S NAME (First, Middle, Last): Eli Acosta | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie (UNKNOWN) | |
| 19a. INFORMANT'S NAME (Type/Print): Jennie E. Acosta | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Pk. | 20c. LOCATION — City or Town, State: Glen Burnie, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, 1 Second Ave. S.W., Glen Bunie, Maryland 21061 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO PULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. UNKNOWN | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D25782 | 5/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type or Print): STEPHEN R. [illegible], M.D. 5 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | [signature] |

DHMH-18 Rev 1/89

89 12925

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Viola Pearl Atkinson | | | 2. DATE OF DEATH (Month, Day, Year): May 25, 1989 | 3. TIME OF DEATH: 11:15 A M |
| 4. SOCIAL SECURITY NUMBER: 217.26.6910 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 6, 1907 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 102 Crain Highway Apt 949 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 102 Crain Highway Apt 949 | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): NA | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Henry H. Wolf | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Blank | | |
| 19a. INFORMANT'S NAME (Type/Print): Joanne L. Schmidt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 336 Gatewater Court Apt 304, Glen Burnie, Md. 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State: Brooklyn Park, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harold B Dyson | | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, 1 Second Avenue S.W., Glen Burnie, Maryland | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ~~CARDIAC~~ ARTERIOSCLEROTIC CARDIO | 5 YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): VASCULAR DISEASE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. HYPERTENSION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. HYPERLIPIDEMIA | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | | | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Attending Physician | D 21776 | ▶ 5/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SURYA P. MUNDRA MD 203 E PATAPSCO AV BALTIMORE MD 21225

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 1252

89 12926

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHRISTOPHER P. BILLMYRE
2. DATE OF DEATH (Month, Day, Year): 5 / 16 / 89
3. TIME OF DEATH: 6:00 A M
4. SOCIAL SECURITY NUMBER: 213-15-0975
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 2 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-20-86
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): ~~Maryland General Hospital~~ 532 FAWN WALK
9b. CITY, TOWN OR LOCATION OF DEATH: ~~Baltimore~~ Annapolis Md.
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis Maryland
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 532 Fawns Walk
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minor
16b. KIND OF BUSINESS/INDUSTRY: —

17. FATHER'S NAME (First, Middle, Last): John Gary Billmyre
18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Siebold Billmyre

19a. INFORMANT'S NAME (Type/Print): ~~Christopher Preston~~ JOHN Billmyre
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 532 Fawns Walk Annapolis Md 21401

20a. METHOD OF DISPOSITION: ~~1 Burial~~ 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Margarets Episcopal Church Annapolis
20c. LOCATION — City or Town, State: Annapolis Md 21401

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: BARRANCO Severna Park MD 21146

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Arrest | Immediate |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Neonatal adrenoleukodystrophy. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N.A.
28b. TIME OF INJURY: — M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: —
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Kenneth C. Schuberth MD
29c. LICENSE NUMBER: D 20489
29d. DATE SIGNED (Month, Day, Year): 5/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kenneth C. Schuberth MD 10807 Falls Rd Lutherville Md 21093
31. DATE FILED (Month, Day, Year): MAY 18 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeck

DHMH-18 Rev 1/89

89 1292

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12927
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Cecil Eugene Bullock | | | 2. DATE OF DEATH: MONTH May DAY 25, YEAR 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 246.48.4559 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 11, 1933 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel Co. |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 207 Lower Magothy Beach Road | | 10f. ZIP CODE: 21146 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lineman | 16b. KIND OF BUSINESS/INDUSTRY: Civil Service U.S. Army Ft. Meade | | |
| 17. FATHER'S NAME (First, Middle, Last): John H. Bullock | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Madeline Smith | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Joan E. Bullock | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Lower Magothy Beach Rd., Severna Park, Md. 21146 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold B Vinson | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): | Hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Hilary O'Herlihy M.D. | 29c. LICENSE NUMBER: D 15860 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-26-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hilary O'Herlihy, M.D. Hospital Drive, Glen Burnie, Maryland 21061 | | |
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 1297

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12928
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hubert H. Bradley
2. DATE OF DEATH (Month, Day, Year): 05-01-89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 565-07-5624A
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04-27-07
8. BIRTHPLACE (State or Foreign Country): North Dakota
9a. FACILITY NAME (If not institution, give street and number): 1033 Indian Landing Road
9b. CITY, TOWN OR LOCATION OF DEATH: Millersville
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: AA
10c. CITY, TOWN OR LOCATION: Millersville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1033 Indian Landing Road
10f. ZIP CODE: 21108
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman
16b. KIND OF BUSINESS/INDUSTRY: Dairy
17. FATHER'S NAME (First, Middle, Last): Franklin H. Bradley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Adra H. Brubaker
19a. INFORMANT'S NAME (Type/Print): Mildred A. Bradley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1033 Indian Landing Road
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery
20c. LOCATION — City or Town, State: Crownsville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robt J Arnold
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. Gambrills, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cancer of lung — DUE TO (OR AS A CONSEQUENCE OF): — 7 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert L. Brimhall MD
29c. LICENSE NUMBER: MD 18466
29d. DATE SIGNED (Month, Day, Year): ▶ 5/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. L. Brimhall, 1833A Forest Drive, MD
31. DATE FILED (Month, Day, Year): MAY 02 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

5+1

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12929 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5, 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| OSWALD U. BYRD | 05 - 08 - 89 | 2155 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-03-6600A | 1 ☒ M 2 ☐ F | 95 YRS. | | | 06-16-93 | BRITISH W.I. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 309 MORRIS HILL AVE | GLEN BURNIE MD | ANNE ARUNDEL CO |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | GLEN BURNIE | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 309 MORRIS HILL AVE | 21061 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JOSIAH BYRD | ELIZABETH |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CLARENCE BYRD | 4911 W FOREST PK AVE BALTO MD 21207 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | ARLINGTON CEMETERY | BALTIMORE, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Marshall P. Stamper | MARSHALL P. HAYES F/H 238 N. Gilmor St BALTO MD 21217 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular Fibrillation | 5 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal failure | 3 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined | 5-8-89 | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ian P. Sherrin MD | | ▶ 5-9-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Harbor Hospital Center ED

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 5 - MAY 11 1989 | Kathleen Pendergast |

OHMH-16 Rev 1/89

89 1292

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12930 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Clara Lee Bubier | | 2. DATE OF DEATH (Month, Day, Year): 05-02-89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218-20-1277 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 06-16-25 |
| 8. BIRTHPLACE (State or Foreign Country): Wash. D.C. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: AA | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD | 10b. COUNTY: AA | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1722 Royden Tr. | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): David Trott | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara E. Turnage | | |
| 19a. INFORMANT'S NAME (Type/Print): Griag Bubier | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 River Plantation Dr. Conroe, TX 77302 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Crematory | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Beth Jacob | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral hOme P.A. 12 Ridgely Avenue, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio pulmonary arrest.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. acute cerebral dysfunction/ stroke
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Schmidlien | D-30741 | ▶ 5-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Schmidlien, 1521 Ritchie Highway, Arnold

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 04 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12931 5/08/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joseph H. Bouchal, SR | | | | 2. DATE OF DEATH (Month, Day, Year): 3 08 89 | 3. TIME OF DEATH: 1510 M |
| 4. SOCIAL SECURITY NUMBER: 213-28-6502 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3/22/06 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Gen Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: A.A. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1109 Poplar Avenue | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance | 16b. KIND OF BUSINESS/INDUSTRY: Hotel | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Edwin Bouchal | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Schiminger | |
| 19a. INFORMANT'S NAME (Type/Print): Eleanora V. Bouchal | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1109 Poplar Avenue, Annapolis, MD 21401 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic C.V.D. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Previous Gastric Ulcer.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William P. Jones, MD Deputy | 29c. LICENSE NUMBER: D06054 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): William P. Jones, MD 695 America Ct. 21035 | | |
| 31. DATE FILED (Month, Day, Year): MAY 09 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

OHMH-15 Rev 1/89

88 15031

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12932

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS FRANK BARBORKA | | | | 2. DATE OF DEATH (Month, Day, Year): May 18, 1989 | 3. TIME OF DEATH: 6:20A M |
| 4. SOCIAL SECURITY NUMBER: 217.05.5224 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec. 5, 1915 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 405 Central Avenue S.W. | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Longshoreman | 16b. KIND OF BUSINESS/INDUSTRY: Local 829 |
| 17. FATHER'S NAME (First, Middle, Last): Thomas A. Barborka | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jo Anna Mary Javorska | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia Scheibe | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 Central Avenue S.W. | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery | 20c. LOCATION — City or Town, State: Crownsville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold B Poulson | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE SUBDURAL HEMATOMA | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. FALL | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. CHRONIC DIFFUSE INTRAVASCULAR COAGULATION | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. WIDELY METASTATIC PROSTATE CANCER | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-30-89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: FELL STRUCK HEAD |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME & HOSPITAL | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): GLEN BURNIE |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. [illegible] MD | 29c. LICENSE NUMBER: D33757 | 29d. DATE SIGNED (Month, Day, Year): 5-16-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 108 ASHINGTON Rd. SGV PK MD 21146 | | |
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum | |

DHMH-18 Rev 1/89

89 1535

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12933
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lillian Marie Bryars
2. DATE OF DEATH (Month, Day, Year): 05-03-89
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 243-38-4028
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-06-96
8. BIRTHPLACE (State or Foreign Country): Troy, New York
9a. FACILITY NAME (If not institution, give street and number): 17 Steele Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: AA
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 17 Steele Avenue
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 8+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Household
17. FATHER'S NAME (First, Middle, Last): Edward Peartree
18. MOTHER'S NAME (First, Middle, Maiden Surname): Genive Jannell
19a. INFORMANT'S NAME (Type/Print): Virginia Rushworth
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4310 Meadowcliff Road, Glenarm, MD 21057
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery
20c. LOCATION — City or Town, State: Arlington, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Patrick Hardesty
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Avenue,, Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D18529
29d. DATE SIGNED (Month, Day, Year): ▶ 5/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): MAY 08 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

89 1233

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12934 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Warren E. Becker, SR | | 2. DATE OF DEATH (Month, Day, Year): 05/06/89 | 3. TIME OF DEATH: 6:30 am M |
| 4. SOCIAL SECURITY NUMBER: 314-18-4474 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 03/29/23 |
| 8. BIRTHPLACE (State or Foreign Country): Indiana | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 808 Barrett Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Arnold | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Arnold | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER: 808 Barrett Avenue | 10f. ZIP CODE: 21012 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 10/03/42 - 05/03/65 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasion |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ ; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Draftsman | 16b. KIND OF BUSINESS/INDUSTRY: Engineering Firm | |
| 17. FATHER'S NAME (First, Middle, Last): Arthur Becker | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Flora Strobel | | |
| 19a. INFORMANT'S NAME (Type/Print): Cecelia Jo Becker | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 Barrett Avenue Arnold MD 21012 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans Cemetery | 20c. LOCATION — City or Town, State: Crownsville, MD Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas E. Barranco | 22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest | immediate |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Esophageal Cancer | 22 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Otis W Brawley, MD | D 37817 | ▶ May 8, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Otis W. Brawley, 1900 Lyttonsville #708 SILVER SPRING, MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 10 1989 | Julia Davidson Randall |

DHMH-18 Rev 1/89

1271

89 1537

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12935
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MELVIN LOUIS BRENDEL | | | | | 2. DATE OF DEATH (Month, Day, Year): May 25, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218 03 5232 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec. 21, 1914 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 229 N. Hammonds Ferry Rd. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Linthicum Heights | | 9c. COUNTY OF DEATH: A.A. | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: A.A. | | 10c. CITY, TOWN OR LOCATION: Linthicum Hts. | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 229 N. Hammonds Ferry Rd. | | | 10f. ZIP CODE: 21090 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd grade; College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance | | 16b. KIND OF BUSINESS/INDUSTRY: Baltimore City | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Brendel | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary ==== | | | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth E. Brendel | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 N. Hammonds Ferry Rd., Linthicum, MD 21090 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Mem. Park | | 20c. LOCATION — City or Town, State: Glen Burnie, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George J. Gonce | | | 22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home, P.A. 4001 Ritchie Hgwy., Baltimore, MD 21225 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Cardiac Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Generalized Arteriosclerosis | 3 yr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| A.C. Sollod M.D. | D10740 | ▶ 5-26-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.C. SOLLOD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 26 1989 | Julia Davison-Lindsay |

DHMH-16 Rev 1/89

88 15832

89 12936

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be detained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

4

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDNA M BROOKS
2. DATE OF DEATH: MONTH 5 DAY 6 YEAR 89
3. TIME OF DEATH: 8:45 A M
4. SOCIAL SECURITY NUMBER: 212-10-4972
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-23-09
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Maryland Manor
9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Pasadena
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 480 Riverside Drive
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Harry Silley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Jacobs
19a. INFORMANT'S NAME (Type/Print): Lester Brooks
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 480 Riverside Drive Pasadena, Maryland 21122
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery
20c. LOCATION — City or Town, State: Balto., Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ George F. Gonce
22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | probable cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF): | minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | bronchopneumonia DUE TO (OR AS A CONSEQUENCE OF): | days |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Parkinsonism

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jerry D. Starbuck, M.D.
29c. LICENSE NUMBER: D29767
29d. DATE SIGNED (Month, Day, Year) ▶ 5-6-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3708 Mountain Rd. Pasadena Md 21122
31. DATE FILED (Month, Day, Year): MAY 10 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DHMH-18 Rev 1/89

89 1236

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12937
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNE MAY CARR | | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 10 / 89 | 3. TIME OF DEATH: 1245 P M |
| 4. SOCIAL SECURITY NUMBER: 214-14-1313 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5/27/20 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 8a. FACILITY NAME (If not institution, give street and number): A.A. MEDICAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: ANNE ARUNDEL |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 110 HEARNE CT. | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN THIRKELD AISQUITH | 18. MOTHER'S NAME (First, Middle, Maiden Surname): RUTH HIGGS | | |
| 19a. INFORMANT'S NAME (Type/Print): GERTRUDE SINGELTON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.BOX 103 RIVA, MD. 21140 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ALL HALLOWS CHURCH CEMT | 20c. LOCATION — City or Town, State: BIRDSVILLE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | 22. NAME AND ADDRESS OF FACILITY: TAYLOR FUNERAL CHAPEL ANNAPOLIS, MD. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC LUNG CA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John D Jackson MD | 29c. LICENSE NUMBER: D30718 | 29d. DATE SIGNED (Month, Day, Year): 5-10-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN D JACKSON MD, 1833 FOREST DR ANNAPOLIS MD 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 11 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12938

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): JANE ELIZABETH CADD

**2. DATE OF DEATH** (Month, Day, Year): 05 28 89

**3. TIME OF DEATH**: 6.20 AM M

**4. SOCIAL SECURITY NUMBER**: 212-12-2580

**5. SEX**: 1 ☐ M 2 ☑ F

**6. AGE** (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 1-26-1908

**8. BIRTHPLACE** (State or Foreign Country): Mississippi

**9a. FACILITY NAME** (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: GLEN BURNIE

**9c. COUNTY OF DEATH**: A.A. COUNTY

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**:

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 3445 Mc Shane WAY

**10f. ZIP CODE**: 21122

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH | College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

**16b. KIND OF BUSINESS/INDUSTRY**: Home

**17. FATHER'S NAME** (First, Middle, Last): John Jones

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Catherine Anderson

**19a. INFORMANT'S NAME** (Type/Print): IRENE Matthews

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3445 Mc Shane WAY - 21122

**20a. METHOD OF DISPOSITION**: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Holy Redeemer Cem.

**20c. LOCATION — City or Town, State**: Balto. Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Joseph N. Zannino Jr

**22. NAME AND ADDRESS OF FACILITY**: JOS. N. ZANNINO FUN. HOME, 263 S. Conkling St. 21224

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Recent cerebro-vascular accident

DUE TO (OR AS A CONSEQUENCE OF): generalized arteriosclerosis.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Septicemia

DUE TO (OR AS A CONSEQUENCE OF): acute urinary tract infection,

c. Type I, diabetes mellitus, insulin dependent,

DUE TO (OR AS A CONSEQUENCE OF):

d. ASHD with atrial fibrillation.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: multiple decubiti

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☑ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☑ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year): NA

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Benjamin A. de Guzman M.D.

**29c. LICENSE NUMBER**: D036 48

**29d. DATE SIGNED** (Month, Day, Year): ▶ 05/28/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type/Print): DR. BENJAMIN A. DE GUZMAN 1720 CRAIN HIGHWAY, GLEN BURNIE, MD. 21061

**31. DATE FILED** (Month, Day, Year): MAY 30 1989

REGISTRAR'S SIGNATURE: Julia Davidson Pindell

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12939
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY B. CHEW | | | | 2. DATE OF DEATH (Month, Day, Year): 5 8 1989 | 3. TIME OF DEATH: 7P.M. M |
| 4. SOCIAL SECURITY NUMBER: 214-16-3045 | 5. SEX: 1 ☐ M 2 ☐ F XXX | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3 3 1913 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): FAIRFIELD NURSING [illegible] CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CROWNSVILLE | | 9c. COUNTY OF DEATH: ANNE ARUNDEL |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO XXX |
| 10e. STREET AND NUMBER: 950 President Street Apt A 1 | | 10f. ZIP CODE: 21403 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO XXX IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO XX Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL BLAKE | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE BLAKE | | |
| 19a. INFORMANT'S NAME (Type/Print): DONALD SNOWDEN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1901 B Copeland Street Annapolis, Md. 21401 | | | |
| 20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PINELAWN MEM. PARK | | 20c. LOCATION — City or Town, State: ANNAPOLIS, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Reese, II | | 22. NAME AND ADDRESS OF FACILITY: WILLIAM REESE & SONS MORTUARY, P.A. 821 West St. Anna., Md. 2140[illegible] | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D0P453 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): ERROL A. Phillips 1835 Forest Drive R, Annapolis, Md 21401 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 1239

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12940

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Phyllas E. CURL / PHyLLAS E. CURL | | | 2. DATE OF DEATH: MONTH 5 / DAY 5 / YEAR 89 | 3. TIME OF DEATH: 7 30 P M |
| 4. SOCIAL SECURITY NUMBER: 483-01-7038 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 75 XXXXXX YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-9-13 XXXXXXXXXXXXXXXX | 8. BIRTHPLACE (State or Foreign Country): IOWA XXXXX |
| 9a. FACILITY NAME (If not institution, give street and number): Pleasant Living Conv. Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis Edgewater | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| FL | Lee | Lehigh Acres | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 6 East Green | 33971 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elemantary/Secondary (0-12) | College (1-4 or 5+) | Bookkeeper/Office Mgr. | Retail Sales |
| | 2 | | |

| 17. FATHER'S NAME (First, Middle, Last) | 16. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Mark F. Enenbach | Anna Lorenzen |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mark L. Curl | 6892 Charleston Ave., Rose Haven, MD 20714 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Arlington Nat'l. Cem. | Arlington, VA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ WM Phyllis RFH | Rausch F.H. PO Box 45 Owings, MD 20736 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Dementia of unknown cause | |
| | DUE TO (OR AS A CONSEQUENCE OF): ? alcoholism | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D18509 | ▶ 5/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 10 1989 | Julia Davidson-Randall |

10

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12941
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAY HOPE CROCKEN | | | | 2. DATE OF DEATH: MONTH 05 DAY 01 YEAR 89 | 3. TIME OF DEATH: 8:20 PM M |
| 4. SOCIAL SECURITY NUMBER: 224-26-1600 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5/5/22 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland Manor Conv. Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: A.A. | | 10c. CITY, TOWN OR LOCATION: Linthicum | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1344 W. Nursey Road | | | 10f. ZIP CODE: 21090 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Malcom Burnell | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Crocken | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 Phirne Road Glen Burnie, Md. 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process Crematory | | 20c. LOCATION — City or Town, State: Catonsville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon | | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | (1) a. CONGESTIVE HEART FAILURE | 3 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): (2) b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE | 10 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): c. CARCINOMA OF CERVIX | 3 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): (3) d. DIABETES MELLITUS | 5 yrs |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SEIZURE DISORDER; ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify); 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harjit Singh MD | 29c. LICENSE NUMBER: D14160 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-2-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harjit Singh, M.D. 5507-E Ritchie Hwy Baltimore, MD 21225 | | |
| 31. DATE FILED (Month, Day, Year): MAY 5 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

DNMH-16 Rev 1/89

89 12Sep1

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12942

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Agnes Crabbs
2. DATE OF DEATH (Month, Day): May 12 89
3. TIME OF DEATH: 11 25 P M
4. SOCIAL SECURITY NUMBER: 217.12.7166
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 25, 1909
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): North Arundel Convalescent Center
9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Glen Burnie
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 115 Highland Road (Marley Park)
10f. ZIP CODE: 21061
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6 — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Diamond Dye Grinder
16b. KIND OF BUSINESS/INDUSTRY: Western Electric
17. FATHER'S NAME (First, Middle, Last): Francis Clemence Rudel
18. MOTHER'S NAME (First, Middle, Maiden Surname): Effie Besling
19a. INFORMANT'S NAME (Type/Print): Mr. Edwin D. Ravadge
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8304 Harris Ave., Baltimore, Maryland 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md. 21234
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins
22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c. Cardiac arrhythmias
DUE TO (OR AS A CONSEQUENCE OF):
d. Lung mass

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
arteriosclerosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D 22206
29d. DATE SIGNED (Month, Day, Year): ▶ 5-13-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 273 B Peninsula Farm Rd Arnold, Md
31. DATE FILED (Month, Day, Year): MAY 15 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89 12943

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS Julian COALE
2. DATE OF DEATH (Month, Day, Year): MAY 3 1989
3. TIME OF DEATH: 1:30 pM
4. SOCIAL SECURITY NUMBER: 214-05-0866
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/09/12
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): AAGH - Anne Arundel Med Cntr
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: AA

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: AA
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 939 Marconi Ave.
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auto Mechanic
16b. KIND OF BUSINESS/INDUSTRY: Auto Repair
17. FATHER'S NAME (First, Middle, Last): Leonard W. Coale
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Wolfe
19a. INFORMANT'S NAME (Type/Print): Ida C. Coale
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 939 Marconi Ave., Annapolis, MD. 21401
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery
20c. LOCATION — City or Town, State: Annapolis, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey S. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel, Annapolis, MD.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Congestive Heart Failure | 3-4 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Ischemic Cardiomyopathy | YRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Atherosclerotic Cardio-Vascular Disease | YRS |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Barry R. Nathanson MD
29c. LICENSE NUMBER: D25454
29d. DATE SIGNED (Month, Day, Year): 5/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARRY R. NATHANSON MD 51 FRANKLIN ST. ANNAP, MD.
31. DATE FILED (Month, Day, Year): MAY 04 1989 — REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12944 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GORDON O'Dell CROCKETT | | | 2. DATE OF DEATH (Month, Day, Year): MAY 12 89 | 3. TIME OF DEATH: 2: A M |
| 4. SOCIAL SECURITY NUMBER: 219-12-2983 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-5-19 | 8. BIRTHPLACE (State or Foreign Country): TEXAS |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL GEN. HOSP | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: A. A. Co |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 701 Glenwood St. | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: AMERICAN IND |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired-U.S.N. | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM Hugh Crockett | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GENEVA McCollum | |
| 19a. INFORMANT'S NAME (Type/Print): NEVA-CAMP | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4500 Belview Ave BALT. Md 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): VAN ALS TYNE | 20c. LOCATION — City or Town, State: VAN-ALS TYNE TEXAS | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles E. Hicks III | 22. NAME AND ADDRESS OF FACILITY: Hicks Funeral Home 1922 Forest Dr. ANNAPOLIS MD 21401 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caussd the death. Do not antar tha mdda of dying, such ss cardiac or respiretory arrest, shock, or heart failure. List only ons ceuss on aech line.

| | | Approximsta Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in desth) → a. CARDIORESPIRATORY ARREST | | 5 MIN |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. RENAL FAILURE | | 2 YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): c. PNEUMONIA WITH SEPSIS | | 2 WEEKS |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | |
|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Scott Eden, M.D. | 29c. LICENSE NUMBER: D 30701 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/14/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT SCOTT EDEN, M.D., 703 GIDDINGS AVE, ANNAPOLIS, MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): MAY 17 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

- 1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12945

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John William Clark | | | | | 2. DATE OF DEATH (Month, Day, Year): May 6, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 578-52-8390 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 48 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): March 3, 1941 | 8. BIRTHPLACE (State or Foreign Country): Washington, D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 1732 Tedbury Street | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Crofton, MD | | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Crofton | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1732 Tedbury Street | | 10f. ZIP CODE: 21114 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accounting Technician | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Government | |
| 17. FATHER'S NAME (First, Middle, Last): William Loon Clark | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Vincentina J. Caruso | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret H. Clark | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10. | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | 20c. LOCATION — City or Town, State: Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pres. | 22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Colon Cancer with metastasis to brain/liver | 6 mo. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiorespiratory Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Liver failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | 28d. DESCRIBE HOW INJURY OCCURED / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| C Slavin MD | D33271 | ▶ May 8, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carl J. Slavin, MD 3231 Superior Lane Bowie, MD 20715

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 10 1989 | Julia Davidson-Ramsey |

6

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12946 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROGER CURRY | | | | 2. DATE OF DEATH (Month, Day, Year): 05-06-89 | 3. TIME OF DEATH: 11:10 PM |
| 4. SOCIAL SECURITY NUMBER: 214-03-8950 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-03-20 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CTR. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: AA CO. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Edgewater | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1032 Wier Road | | 10f. ZIP CODE: 21037 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: W W II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Contractor | 16b. KIND OF BUSINESS/INDUSTRY: Building | |
| 17. FATHER'S NAME (First, Middle, Last): Artis Curry | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Flossie Crotts | |
| 19a. INFORMANT'S NAME (Type/Print): Reta Sharpe Curry | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1032 Wier Rd., Edgewater, MD 21037 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery | 20c. LOCATION — City or Town, State: Davidsonville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul A. Fay | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebrovascular accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D26943 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): MAY 09 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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89 1296

89 12947

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM PERRY CHESSHIRE | | | 2. DATE OF DEATH (Month, Day, Year): May 26, 1989 | 3. TIME OF DEATH: 1740 M |
| 4. SOCIAL SECURITY NUMBER: 215-12-4648 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 18, 1921 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 328 Highland Drive T4 | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th. College (1-4 or 5+): 1 Year | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineering Manager | 16b. KIND OF BUSINESS/INDUSTRY: Telegraph International Telephone & |
| 17. FATHER'S NAME (First, Middle, Last): William Chesshire | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Gillam | |
| 19a. INFORMANT'S NAME (Type/Print): Miss Mary Claire Chesshire | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3025 North Calvert St., E1, Baltimore, Md. 21218 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins | | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, Maryland 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carotid Endarterectomy

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William P. Jones MD Deputy | 29c. LICENSE NUMBER: D06054 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/26/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William P. Jones MD 695 America Ct. 21035 | | |
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12948 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCES A CUCINA
2. DATE OF DEATH (Month, Day, Year): 05 01 89
3. TIME OF DEATH: 620 PM M
4. SOCIAL SECURITY NUMBER: 214 20 0051
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 13, 1925
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: A.A. COUNTY
RESIDENCE OF DECEDENT
10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Pasadena
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1084 Woodlawn Ave.
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher's Aide
16b. KIND OF BUSINESS/INDUSTRY: Public Schools
17. FATHER'S NAME (First, Middle, Last): Robert Thomas Ryan
18. MOTHER'S NAME (First, Middle, Maiden Surname): Almeda F. Divel
19a. INFORMANT'S NAME (Type/Print): Richard J. Cucina
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1084 Woodlawn Ave., Pasadena, Maryland 21122
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park
20c. LOCATION — City or Town, State: Elkridge, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Steph D. Lohmann
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | MEDIASTINAL MASS, Pathology Undetermined DUE TO (OR AS A CONSEQUENCE OF): | unknown |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. | CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): | unknown |
| c. | ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): | 10 days |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPONATREMIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Joyce Evans, MD
29c. LICENSE NUMBER: D37036
29d. DATE SIGNED (Month, Day, Year): 05/01/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOYCE EVANS, M.D. 4191 MOUNTAIN ROAD PASADENA, MARYLAND 21122
31. DATE FILED (Month, Day, Year): MAY 8 1989
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12949 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FRANK C. DULANEY SR. | | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 7 / 89 | 3. TIME OF DEATH: P M |
| 4. SOCIAL SECURITY NUMBER: 225 05 4600 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec. 13, 1915 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): 1175 Bay Ridge Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 1175 Bay Ridge Road | | 10f. ZIP CODE: 21403 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Installer-Asbestos | 16b. KIND OF BUSINESS/INDUSTRY: Civil Service | | | | |
| 17. FATHER'S NAME (First, Middle, Last): John Hedgeman Dulaney | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora Gertrude Campbell | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Ann Good Dulaney | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1175 Bay Ridge Road, Annapolis, MD 21403 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Rectal Cancer | 2 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ernest W Cole MD | D16354 | ▶ 5/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. W. COLE 51 FRANKLIN ST ANNAP MD 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 09 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12950
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Martha A. DeWitt | | | 2. DATE OF DEATH (Month, Day, Year): 05-06-89 | 3. TIME OF DEATH: 1:22 P.M |
| 4. SOCIAL SECURITY NUMBER: 023-20-1158 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06-23-11 | 8. BIRTHPLACE (State or Foreign Country): Massachusetts |
| 9a. FACILITY NAME (If not institution, give street and number): Pleasant Living Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Edgewater | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arudnel | 10c. CITY, TOWN OR LOCATION: Mayo | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1620 Cliff Drive, Cloverlea | | 10f. ZIP CODE: 21106 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No--- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Air Traffic Controller | | 16b. KIND OF BUSINESS/INDUSTRY: Federal Aviation Ad. |
| 17. FATHER'S NAME (First, Middle, Last): Christopher Hesse | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Jacoby | |
| 19a. INFORMANT'S NAME (Type/Print): Richard C. Gilson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 Walker St. Lenox, Mass. 01240 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery | | 20c. LOCATION — City or Town, State: Davidsonville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph J. Hubbard Jr. | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Aven. Annapolis, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Alzheimers disease | 5years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. — | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. — | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pneumonitis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles W. Kinzer | DO 5928 | ▶ May 9, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles W. Kinzer, MD, 1833 Forest Dr. Annapolis, MD 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 10 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12951

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert Wesley Dravo | | 2. DATE OF DEATH (Month, Day, Year): 4-18-89 | 3. TIME OF DEATH: 3:48 PM |
| 4. SOCIAL SECURITY NUMBER: 214-66-3335 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 33 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 33 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 3027 Marlin Drive | 9b. CITY, TOWN OR LOCATION OF DEATH: Riva | 9c. COUNTY OF DEATH: Anne Arundel Co. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Riva | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3027 Marlin Drive | 10f. ZIP CODE: 21140 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bricklayer | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Charles A. Dravo | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Regenia Phipps | |
| 19a. INFORMANT'S NAME (Type/Print): Regenia Dravo | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3027 Marlin Dr. Riva, Md. 21140 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetary | 20c. LOCATION — City or Town, State: Annapolis, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey S. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel Annapolis, Md. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Dilated cardiomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fatty liver

Obesity

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: ☒ 1 Natural; 2 ☐ Accident; 3 ☐ Suicide; 4 ☐ Homicide; 5 ☐ Pending Investigation; 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Ann Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-20-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. | 111 Penn Street, Baltimore, MD 21201 vc | |
| 31. DATE FILED (Month, Day, Year): APR 21 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

6

89 12951

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12952

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NICHOLAS JACOB DUPSKI | | | | | 2. DATE OF DEATH (Month, Day, Year): May 07 1989 | | 3. TIME OF DEATH: 4.50 PM M |
| 4. SOCIAL SECURITY NUMBER: 385.28.6655 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan. 11, 1906 | | 8. BIRTHPLACE (State or Foreign Country): Austria |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | | 9c. COUNTY OF DEATH: A.A. COUNTY | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 7949 Crownsway | | 10f. ZIP CODE: 21061 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+): None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Barber | | | 16b. KIND OF BUSINESS/INDUSTRY: Lord Baltimore Hotel | | |
| 17. FATHER'S NAME (First, Middle, Last): Leopold Dupski | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Fitz | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Josephine A. Dupski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery | | | 20c. LOCATION — City or Town, State: Brooklyn Park, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. B. Vinson | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md.21061 | | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIAC ARREST

DUE TO (OR AS A CONSEQUENCE OF):
b. CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF):
c. SEPTICEMIA

DUE TO (OR AS A CONSEQUENCE OF):
d. ADVANCE CARCINOMA OF STOMACH

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Antonio O. Gaudula

29c. LICENSE NUMBER: D18253

29d. DATE SIGNED (Month, Day, Year): ▶ 5-8-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 23) (Type/Print): ANTONIO O. GAUDULA, M.D. 300 HOSPITAL DRIVE, SUITE 30 GLEN BURNIE, MARYLAND 2106

31. DATE FILED (Month, Day, Year): MAY 9 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12953
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MORGAN DELAYNE DELOST | | 2. DATE OF DEATH (Month, Day, Year): May 13 89 | 3. TIME OF DEATH: 5:19 P M |
| 4. SOCIAL SECURITY NUMBER: 216-86-5187 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 13 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 19, 1975 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): woods off Roberts Court Shelley Rd. | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 109 Vernon Ave. | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th. College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: Jr. High School | |
| 17. FATHER'S NAME (First, Middle, Last): John M. DeLost | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Cynthia L. Potter | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Cynthia L. DeLost | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Vernon Ave. , Glen Burnie, Maryland 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, Maryland 21061 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple Stab Wounds | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) scene | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5-13-89 | 28b. TIME OF INJURY: 5:00 P M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| 28d. DESCRIBE HOW INJURY OCCURED: subject was stabbed | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): woods | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): off Robert Ct. Shelley Rd., Anne Arundel Co., Md. | | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn St., Balto., Md. 21201 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12954 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sheila Dabney
2. DATE OF DEATH (Month, Day, Year): 5/2/89
3. TIME OF DEATH: 9:30 A M
4. SOCIAL SECURITY NUMBER: 577-82-7819
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 38 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 5/10/50
8. BIRTHPLACE (State or Foreign Country): U.S.
9a. FACILITY NAME (If not institution, give street and number): D.C. Children's Center
9b. CITY, TOWN OR LOCATION OF DEATH: Laurel, MD 20707
9c. COUNTY OF DEATH: Anne Arundel, MD

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Laurel MD
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3360 Center Avenue Laurel MD
10f. ZIP CODE: 20707
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Willie Dabney
18. MOTHER'S NAME (First, Middle, Maiden Surname): Pearlie Dabney
19a. INFORMANT'S NAME (Type/Print): Phyliis Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3360 Center Ave; Laurel, MD 20707
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Cemetery
20c. LOCATION — City or Town, State: Landover, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Garland Wheeler
22. NAME AND ADDRESS OF FACILITY: W.W. Chambers Company 517 11th St; S.E. Washington D.C.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-pulmunary failur
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cerebral agenesis
DUE TO (OR AS A CONSEQUENCE OF):
c. ~~Pneu~~ profund mental retardation
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N.A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Forest Haven
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): —
28b. TIME OF INJURY: — M
28c. INJURY AT WORK? N.A. 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N.A.
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N.A.
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3360 Center Avenue Laurel Md. 20707

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Kavoos Sinai M.D.
29c. LICENSE NUMBER: 3538 D.C.
29d. DATE SIGNED (Month, Day, Year): 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KAVOOS SINAI, M.D; 3360 Center La; Laurel, Md.
31. DATE FILED (Month, Day, Year):
32. REGISTRAR'S SIGNATURE:

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Phyllis Smith 3320 Contee Ave. Laurel, Md. 20707

Harmony Cemetery Landover, Md.

W.M. Champlin & Company

517 11th St. S.E. Washington, D.C.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12955

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN Loraine DAILEY | | | 2. DATE OF DEATH Month: May Day: 25, Year: 1989 | 3. TIME OF DEATH: 0228 PM M |
| 4. SOCIAL SECURITY NUMBER: 234.54.3022 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 54 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): March 20, 1935 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 775 221st Street | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 8+): NA | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Woodrow Rhodes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae Leary | |
| 19a. INFORMANT'S NAME (Type/Print): Edward W. Dailey | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Vance Hopkins | | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home, 1 Second Avenue S.W., Glen Burnie, Md. 21061 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Small Bowel Obstruction | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Abdominal Carcinomatosis | 4 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Grand mal seizure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D20431 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-26-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): LONG S. HSU, M.D. 300 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061 | | |
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 12956

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Theodore Stanley Entwisle Sr.
2. DATE OF DEATH (Month, Day, Year): 5-2-89
3. TIME OF DEATH: 1:30 a M
4. SOCIAL SECURITY NUMBER: 577-07-1697
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In years last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 3-06-06
8. BIRTHPLACE (State or Foreign Country): Washington, D.C
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Ann e Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: AA
10c. CITY, TOWN OR LOCATION: Edgewater
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1133 Turkey Point Road
10f. ZIP CODE: 21037
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 3
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Restaurant /Salesman
16b. KIND OF BUSINESS/INDUSTRY: Restuarant Supplies
17. FATHER'S NAME (First, Middle, Last): Charles Entwisle Sr.
16. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Swindells
19a. INFORMANT'S NAME (Type/Print): Lorena Aist Entwisle
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1133 Turkey Point Road
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mayo Mem. United Methodist Churdh
20c. LOCATION — City or Town, State: Edgewater, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kimberly S Rowe
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Avenue, MD

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION — 10 days

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CORONARY ARTERY DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

c. ATHEROSCLEROSIS

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE CARDIAC FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Frank Gross MD.
29c. LICENSE NUMBER: D13044
29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK GROSS MD 2525 RIVARD ANNAPOLIS 21401
31. DATE FILED (Month, Day, Year): MAY 08 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

30

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12957 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

N

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Paula G. French | | | | | 2. DATE OF DEATH (Month, Day, Year): May 12, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 216-70-4893 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb. 2, 1904 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | | 10c. CITY, TOWN OR LOCATION: Annapolis | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 207 McKendree Avenue | | | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Arthur Grollman | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Zorn | | | |
| 19a. INFORMANT'S NAME (Type/Print): Sidney W. French, Jr. | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 158 Old Mill Bottom Rd., Annapolis, MD 21401 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan | | 20c. LOCATION — City or Town, State: Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey L. Taylor | | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIAC ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ACUTE MYOCARDIAL INFARCTION | 2 Day. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D70718 | ▶ 5/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN T. NELSON 1833 FOREST DR ANNAPOLIS MD 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 16 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12958

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eleanor H. Freaner
2. DATE OF DEATH (Month, Day, Year): 5-23-89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-20-6957
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-10-04
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Greenbelt
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 22 B Ridge Road
10f. ZIP CODE: 20770
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years — College (1-4 or 5+): 1 year
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: not applicable
17. FATHER'S NAME (First, Middle, Last): Ralphael H. Berrecloth
16. MOTHER'S NAME (First, Middle, Maiden Surname): Margueritte Benner
19a. INFORMANT'S NAME (Type/Print): George V. Freaner, Jr. (son)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 419 C. John Brown Rd. Queenstown Md. 21658
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew Borgwardt
22. NAME AND ADDRESS OF FACILITY: Borgwardt Funeral Home, 4400 Powder Mill Road, Beltsville, Md. 20705

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Brain Cancer

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jon B. Loose MD
29c. LICENSE NUMBER: D18529
29d. DATE SIGNED (Month, Day, Year): ▶ 23 May 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jon B. Loose MD 77 West St. Annapolis, Md 21401

31. DATE FILED (Month, Day, Year): MAY 24 1989
32. REGISTRAR'S SIGNATURE: Julia Denson-Randall

10

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12959 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eleanor W. Free | | | | 2. DATE OF DEATH (Month, Day, Year): 05-06-89 | 3. TIME OF DEATH: 7:10a. M |
| 4. SOCIAL SECURITY NUMBER: 234-05-9042 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 08-23-17 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: AA |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: AA | 10c. CITY, TOWN OR LOCATION: Edgewater | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1609 Fairhill Drive | | 10f. ZIP CODE: 21037 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Household | |
| 17. FATHER'S NAME (First, Middle, Last): Roy J. Bell | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Charles W. Free | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1609 Fairhill Drive, Edgewater, MD 21037 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery | | 20c. LOCATION — City or Town, State: Cheltenham, PG Co. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bill J Hardesty | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Fuenral Home P.A. 12 Ridgely Avenue, MD | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic heart disease — arrhythmia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.O.P.D.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D23142 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S.D. KRAMER M.D. 25 SHAW ST. ANNA., MD. 21401 | | |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

OHMH-16 Rev 1/89

89 1295

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12960

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): JULIA A GREGOR
2. DATE OF DEATH: MONTH 5 DAY 6 YEAR 1989
3. TIME OF DEATH: 2:45 PM
4. SOCIAL SECURITY NUMBER: 234-44-3136
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 03-28-05
8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel Co.

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Glen Burnie
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 419 Cody Drive
10f. ZIP CODE: 21061
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th Grade — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Homemaker
17. FATHER'S NAME (First, Middle, Last): Andy Eslary
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora (Remmo)
19a. INFORMANT'S NAME (Type/Print): Barbara Kearney
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 Cody Dr., Glen Burnie, MD 21061
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): I.D.O.F. Cemetery
20c. LOCATION — City or Town, State: Farmington, W. VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Gregg Burk
22. NAME AND ADDRESS OF FACILITY: Dent Funeral Home, Rt. 250 Farmington, W. VA 26571

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

c. ARTERIOSCLEROTIC CARDIOVASCULAR

DUE TO (OR AS A CONSEQUENCE OF):

d. DISEASE WITH ARRYTHMIA

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CEREBROVASCULAR ACCIDENT

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C.V. Cyriac M.D. PRIVATE DOCTOR
29c. LICENSE NUMBER: D21684
29d. DATE SIGNED (Month, Day, Year): ▶ 5.6.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.V. CYRIAC-M-D 14 WELLHAM AVE. GLENBURNIE. MD 21061

31. DATE FILED (Month, Day, Year): MAY 8 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 1290

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12961

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Louise Fifer Girardi | | | | 2. DATE OF DEATH (Month, Day, Year): 05-01-89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 217-58-0713 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-03-03 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Pleasant Living Nursing Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Edgewater | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD | 10b. COUNTY: AA | 10c. CITY, TOWN OR LOCATION: Edgewater | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 144 Washington Road | | 10f. ZIP CODE: 21037 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Household | | | |
| 17. FATHER'S NAME (First, Middle, Last): William T. Fifer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Louise Hartge | | | |
| 19a. INFORMANT'S NAME (Type/Print): Charlotte Sears | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 Taylor Avenue,, Annapolis, MD | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Quaker Cemetery, | | 20c. LOCATION — City or Town, State: Galesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kimberly S. Howe | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. Galesville, MD | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. RESPIRATORY ARREST | (minutes) |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CORONARY HEART DIS + CONG. HEART FAILURE | YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D30714 | ▶ 5-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN JACKSON MD, 1833 FOREST DR ANNAPOLIS MD 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 04 1989 | Julia Davidson-Rodell |

DHMH-16 Rev 1/89

4

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12962

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Paul Edwin Gause | | | 2. DATE OF DEATH (Month, Day, Year): May 23, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218.28.4132 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 18, 1932 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 722 Delmar Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 722 Delmar Avenue | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korean | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+): None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembler | | 16b. KIND OF BUSINESS/INDUSTRY: Martin Marietta |
| 17. FATHER'S NAME (First, Middle, Last): Frederick Charles Gause | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Allen | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Catherine A. Gause | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 722 Delmar Avenue, Glen Burnie, Md.21061 | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery | | 20c. LOCATION — City or Town, State: Crownsville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Maryland | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William P. Jones, MD Deputy | 29c. LICENSE NUMBER: D0C054 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/23/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): William P. Jones, MD 695 America Ct. 21035 | | |
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landress | |

OHMH-16 Rev 1/89

89 1292

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12963
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ruth Waters Gale | | | | | 2. DATE OF DEATH (Month, Day, Year): May 23, 1989 | 3. TIME OF DEATH: 3:35 A M |
| 4. SOCIAL SECURITY NUMBER: 212.74.9939 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 98 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 9,1890 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 955 Patuxant Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Odenton | | | 9c. COUNTY OF DEATH: Anne Arundel |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | | 10c. CITY, TOWN OR LOCATION: Odenton | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 955 Patuxant Road | | | 10f. ZIP CODE: 21113 | | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+): NA | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Edward Waters | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): (Unknown) | | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret Mills | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | | | 20c. LOCATION — City or Town, State: Glen Burnie, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald B Wilson | | | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Ave. S.W. Glen Burnie, Maryland 21061 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary Artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Advanced age of 98 yrs | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced age
Coronary Artery Disease

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: N/A | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ronald C. Sroka | D1848 | ▶ 5/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ronald C. Sroka, M.D. 3 Village Green, Crofton, Md. 21114

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 1263

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12964

DIVISION OF VITAL RECORDS, P.O. BOX 1314 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Oscar Gingrich | | | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 13 / 89 | | 3. TIME OF DEATH: 2130 M |
| 4. SOCIAL SECURITY NUMBER: N/A | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5/26/12 | | 8. BIRTHPLACE (State or Foreign Country): N/A |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Gen. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | | 9c. COUNTY OF DEATH: A A | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Shady Side | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1212 Avalon Blvd. | 20764 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [ ] NO N/A IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: Caucasian |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | N/A | N/A |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| N/A | N/A |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Paul R. Shelby | 14300 Gallant Fox Lane Bowie, MD 20715 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Metropolitan Crematory | Alexandria, Virginia |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Robert E. Evans, Pres. | Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple Trauma; DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Motor Vehicle Accident DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 4/13/89 | 2130 | 1 [ ] YES 2 [X] NO | Motor Vehicle Acc. |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): RTE 255 |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William P. Jones MD | D06054 | ▶ 4/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William P. Jones MD 695 America Ct. 21035

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 17 1989 | |

6

DHMH-16 Rev 1/89

Items 23a thu 28f Per M.E. FilmG652 6/19/89 CG

89 12965

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elsie Mae Gilbert | | | 2. DATE OF DEATH (Month, Day, Year): 5-21-89 | 3. TIME OF DEATH: 11:05AM M |
| 4. SOCIAL SECURITY NUMBER: 216-36-2708 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 20, 1939 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): North Arundel General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 112 New Jersey Ave., N.W. | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Billing Clerk | 16b. KIND OF BUSINESS/INDUSTRY: North Arundel Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): James Wilmer Carrick | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Alma Jean Heron | |
| 19a. INFORMANT'S NAME (Type/Print): Sandra L. Spies | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 650 Charante Cir., Apt. 104, Glen Burnie, MD 21061 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, A.A., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, MD 21061 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-23-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-16 Rev 1/89

89 1965

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12966
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donald Kenneth Genson, Sr. | | | | 2. DATE OF DEATH (Month, Day, Year): 5 21 89 | 3. TIME OF DEATH: 1250 A - M |
| 4. SOCIAL SECURITY NUMBER: 084-24-2891 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 5, 1931 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Upper Marlboro | 10d. INSIDE CITY LIMITS? [X] 1 YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 14217 Rutherford Drive | | 10f. ZIP CODE: 20772 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean Conflict | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (12); College (1-4 or 5 +): (4) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Insurance Agency Broker | 16b. KIND OF BUSINESS/INDUSTRY: Own Business |
| 17. FATHER'S NAME (First, Middle, Last): Ernest L. Genson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura --- Janniszewski | |
| 19a. INFORMANT'S NAME (Type/Print): Jean A. Genson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14217 Rutherford Rd., Upper Marlboro, Md. 20772 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | 20c. LOCATION — City or Town, State: Alexandria, Va. 22310 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard A. Coleman | | 22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home, Upper Marlboro, Maryland 20772 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of prostate with metastases | 2 mos |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D-12452 | ▶ 5/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD N. PEELER MD, ANNAPOLIS, MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 24 1989 | Julia Davidson-Rudasill |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12967

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARTIN W. HOLMSTED | | | 2. DATE OF DEATH (Month, Day, Year): May 5, 1989 | 3. TIME OF DEATH: 3:30a. M |
| 4. SOCIAL SECURITY NUMBER: 216-05-4268 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 13, 1907 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 193 Berrywood Dr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Severna Park | 9c. COUNTY OF DEATH: Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City, | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 5411 Gerland Ave. | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foundryman | 16b. KIND OF BUSINESS/INDUSTRY: Metal | |
| 17. FATHER'S NAME (First, Middle, Last): Martin Holmsted | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Olsen | | |
| 19a. INFORMANT'S NAME (Type/Print): Marilyn Stallings | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 193 Berrywood Dr. Severna Park, Md. 21146 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Mem. Park 5/8/89 | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. HArtsock, Jr. ▶ Paul L. Hartsock Jr. | | 22. NAME AND ADDRESS OF FACILITY: Baltimore, Maryland21214 Leonard J. Ruck, Inc. 5305 Harford Rd. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | 1 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Esophagus Cancer | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D27295 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael H. Blume, M.D. Good Samartian Professional Building Suite 102

31. DATE FILED (Month, Day, Year): MAY 8 1989 | REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

89 1294

89 12968

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA LEE HANCOCK | | 2. DATE OF DEATH (Month, Day, Year): May 5, 1989 | 3. TIME OF DEATH: 10:30 AM |
| 4. SOCIAL SECURITY NUMBER: 216 12 3503 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 1, 1914 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center, Hammonds Ln | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 101 14th. Avenue | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Charles R. Patterson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith Maud Millar | | |
| 19a. INFORMANT'S NAME (Type/Print): Helene Patterson Riser | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 707 E. Maple Rd. Linthicum, Md. 21090 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Brooklyn Park, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George Gonce | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. arteriosclerotic cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carlos D Zigel MD | 29c. LICENSE NUMBER: D29807 | 29d. DATE SIGNED (Month, Day, Year): 5/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CARLOS D. ZIGEL MD | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-18 Rev 1/89

89 1298

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12969
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): MARY K HURLEY

**2. DATE OF DEATH** (Month, Day, Year): 05 09 89

**3. TIME OF DEATH**: 1222 PM M

**4. SOCIAL SECURITY NUMBER**: 215-18-1030

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 04/17/21

**8. BIRTHPLACE** (State or Foreign Country): Pennsylvania

**9a. FACILITY NAME** (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: GLEN BURNIE

**9c. COUNTY OF DEATH**: A.A. COUNTY

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Anne Arundel

**10c. CITY, TOWN OR LOCATION**: Glen Burnie

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 5017 Brookwood Road

**10f. ZIP CODE**: 21061

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**
1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: white

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4 or 5 +):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): lineworker

**16b. KIND OF BUSINESS/INDUSTRY**: distillary

**17. FATHER'S NAME** (First, Middle, Last): Delphia Trish

**16. MOTHER'S NAME** (First, Middle, Maiden Surname): Cora Mae Coppersmith

**19a. INFORMANT'S NAME** (Type/Print): Kathryn H. Edel

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 701 Bedford Road, Belair, Maryland 21014

**20a. METHOD OF DISPOSITION**
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Cedar Hill Cemetery

**20c. LOCATION — City or Town, State**: Brooklyn Park, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶ [signature]

**22. NAME AND ADDRESS OF FACILITY**: Ambrose Funeral Home, Inc.
1328 Sulphur Spring Road, Arbutus, Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** →
a. Cardio respiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
b. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**
Ventricular Arrhythmia
Cardiomyopathy

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**
1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] MD

**29c. LICENSE NUMBER**: D28624

**29d. DATE SIGNED** (Month, Day, Year) ▶ 5/10/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type/Print): BASANT K. KHANDELWAL, M.D. 7422 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYL

**31. DATE FILED** (Month, Day, Year): MAY 11 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Pendrey

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12970 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Walter HARPER | | | | 2. DATE OF DEATH (Month, Day, Year): 5 10 89 | 3. TIME OF DEATH: 5:15 P.M. |
| 4. SOCIAL SECURITY NUMBER: 215-26-3136 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4 10 20 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Med. Center | | | 9b. CITY, TOWN OR LOCATION, OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: aa co |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: HARWOOD | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1501 B Berkley Court | | 10f. ZIP CODE: 20766 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO; IF YES, GIVE WAR OR DATES XX | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CUSTODIAN | 16b. KIND OF BUSINESS/INDUSTRY: BOARD OF EDUCATION |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): THOMAS HARPER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DORA HAWKINS |
| 19a. INFORMANT'S NAME (Type/Print): JENNIFER HUGGINS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 305 S. Pulaski Street Balto. Md. 21223 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOSES CEMETERY | 20c. LOCATION — City or Town, State: DRURY A.A. MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Reese, II | 22. NAME AND ADDRESS OF FACILITY: WILLIAM REESE & SONS MORTUARY, P.A. 821 West Street Annapolis, Maryland 21401 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Liver failure | 3-4 wks |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Laennec's Cirrhosis of Liver | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter F. Verkouw MD | 29c. LICENSE NUMBER: D 11653 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER F. VERKOUW MD 1833 Forest Drive, Annapolis, Md 21401 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

5

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12971 REG. NO.

2

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIAN Ruth HALL | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 15 / 89 | | 3. TIME OF DEATH: 12:30 pm M |
| 4. SOCIAL SECURITY NUMBER: 052-18-1342 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Apr. 30, 1913 |
| 8. BIRTHPLACE (State or Foreign Country): Chile | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): PLEASANT LIVING CONV. CTR. | | 9b. CITY, TOWN OR LOCATION OF DEATH: EDGEWATER | | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Edgewater | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 334 Riverside Road | | 10f. ZIP CODE: 21037 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Arnold J. Noerager | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise HENRIETTA BEYERMANN | | | |
| 19a. INFORMANT'S NAME (Type/Print): Medora O. Higdon | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3059 Evans Road, Riva, Maryland 21140 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan | | 20c. LOCATION — City or Town, State: Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey S. Layla | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Anemia | Mos |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Bone marrow infiltration | 1 year |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | multiple myelosma | 5 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Peter F. Verkouw MD | D11653 | 5/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER F. VERKOUW 1833 Forest Drive, Annapolis, Md 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 16 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

20

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12972

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 of 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANN HOGAN | | | | | 2. DATE OF DEATH (Month, Day, Year): 4 22 89 | 3. TIME OF DEATH: 11:10 AM |
| 4. SOCIAL SECURITY NUMBER: 078-24-9683 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 29, 1898 | 8. BIRTHPLACE (State or Foreign Country): Ireland |
| 9a. FACILITY NAME (If not institution, give street and number): Crofton Convalesent Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Crofton | | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Wisconsin | 10b. COUNTY: Waukesha | 10c. CITY, TOWN OR LOCATION: Elm Grove | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 15380 Westover Road | | 10f. ZIP CODE: 53122 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): John Reid | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Hogan | |
| 19a. INFORMANT'S NAME (Type/Print): J. Gerard Hogan | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10. | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | 20c. LOCATION — City or Town, State: Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans, Pres. | 22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, MD 20715 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Left ventricular failure | minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Renal insufficiency | days |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Hypertensive Cardiovascular disease | yrs |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: DO 1828 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/24/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAX C FRANK MD 7575 Ritchie Hwy Glen Burnie Maryland 21061 | | |
| 31. DATE FILED (Month, Day, Year): MAY 3 - 1989 | REGISTRAR'S SIGNATURE | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12973 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| EARL | NONE | HARDY | 05 MONTH 05 DAY 89 YEAR | 0254 PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 705-10-2400 | 1 [X] M 2 [ ] F | 81 YRS. | | | 2/10/1908 | Illinois |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | ---- | Baltimore | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1609 Cypress Street, | 21226 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 8+) | | |
| 7 | | Ret. Ass't. Car Foreman | B & O Railroad |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Edgar Hardy | KIZZIE M. BRADFIELD HARDY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Earl A. Hardy | 1842 Cremen Road, Pasadena, Maryland 21122 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Kevin E. Ecker | McCully Funeral Home of Brooklyn<br>237 E. Patapsco AVe., Balto., Md. 21225 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Prostate Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | 027938 | ▶ 5/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type or Print) DR. M. GORDATT 95 AQUAHART RD. GLEN BURNIE, MD. 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Julia Davidson-Landeck |

DHMH-16 Rev 1/89

ERES: 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12974

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Henry Franklin Huber, Jr. | | | 2. DATE OF DEATH (Month, Day, Year): May 23, 1989 | 3. TIME OF DEATH: 1315 M |
| 4. SOCIAL SECURITY NUMBER: 220.09.2701 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 17, 1920 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 205 Bay Front Drive | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): NA | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed | 16b. KIND OF BUSINESS/INDUSTRY: Electrical Contractor | |
| 17. FATHER'S NAME (First, Middle, Last): Henry Franklin Huber, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hilda Gomprecht | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth B. Huber | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Pikesville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins | | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Avenue S.W. Glen Burnie, Maryland 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Probably Pulmonary embolus
DUE TO (OR AS A CONSEQUENCE OF):
c. Prostate Cancer
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mohamad Hussein | 29c. LICENSE NUMBER: D381-64 | 29d. DATE SIGNED (Month, Day, Year) ▶ 052489 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mohamad Hussein, M.D. University Hospital, Baltimore, Maryland | | |
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau | |

DHMH-16 Rev 1/89

APR 1989

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12975

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Herbert Monroe Helm | | | | | 2. DATE OF DEATH (Month, Day, Year): May 10, 1989 | 3. TIME OF DEATH: 2:45 am M |
| 4. SOCIAL SECURITY NUMBER: 219 32 1262 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): March 26, 1901 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 389 Edgewater Rd., | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Pasadena | | | 9c. COUNTY OF DEATH: Anne Arundel |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | | 10c. CITY, TOWN OR LOCATION: Pasadena | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 389 Edgewater RD. | | | 10f. ZIP CODE: 21122 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed (Broker) | | 16b. KIND OF BUSINESS/INDUSTRY: Insurance | |
| 17. FATHER'S NAME (First, Middle, Last): William M. Helm | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice B. Boblett | | | |
| 19a. INFORMANT'S NAME (Type/Print): Katherine S. Helm | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 389 Edgewater Rd., Pasadena, MD 21122 | | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Schumann | | | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of the Lung | one year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Cole, M.D. | D21512 | ▶ 5/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Jeffrey F. Cole, M.D., 3455 Wilkens Avenue, Baltimore, Maryland 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Julia Davidson-Landeen |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12976 — 5/8/89

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edgar C. Jones | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 08 / 89 | | 3. TIME OF DEATH: 820 pm M |
| 4. SOCIAL SECURITY NUMBER: 214-46-1563 | 5. SEX: 1 ☐ M 2 ☐ F XX | 6. AGE (In yrs. last birthday): 43 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2 7 46 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Deaton Hospital + medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: A.A |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1195 Madison Street Apt. 1 | | 10f. ZIP CODE: 21403 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced XXX | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO XXX IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO XXX Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNENPLOYED | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): EDGAR K. JONES | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY J. BROWN | |
| 19a. INFORMANT'S NAME (Type/Print): AGNES MURRAY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 423 Knottwood Court Arnold, Md. 21012 | |
| 20a. METHOD OF DISPOSITION: XX 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND VETERAN CEME. | 20c. LOCATION — City or Town, State: CROWNSVILLE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William Reese, II | 22. NAME AND ADDRESS OF FACILITY: 821 West Street Anna., Md. WILLIAM REESE & SONS MORTUARY, P.A. 21401 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | SEPSIS | DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | DECUBITUS ULCERS | DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ANOXIC ENCEPHALOPATHY, SEIZURE DISORDER

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N A | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Pritam S. Saini MD | 29c. LICENSE NUMBER: D28998 | 29d. DATE SIGNED (Month, Day, Year): 5-9-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PRITAM S. SAINI MD, 14333 LAUREL BOWIE RD, # 303 LAUREL MD 20708 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12977
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Inez Monroe Kelly | | | 2. DATE OF DEATH (Month, Day, Year): May 7 1989 | 3. TIME OF DEATH: 5:13 AM M |
| 4. SOCIAL SECURITY NUMBER: 240.32.1751 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 19, 1905 | 8. BIRTHPLACE (State or Foreign Country): N. Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland Manor Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7575 E. Howard Road | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): Unknown | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Henry Monroe | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Peggy A. Miller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 606 Millwright Ct., Apt 11, Millersville, Md.21108 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Security Process, Inc. | 20c. LOCATION — City or Town, State: Catonsville,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. probable cardiac arrhythmia | minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. sepsis | day |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. chronic and recurrent pneumonia | months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: cerebrovascular accident 12/88

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Jerry D. Stubbs, M.D. | 29c. LICENSE NUMBER: D29767 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3708 Mountain Rd Pasadena, Md 21122

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12978
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald H. Kellenberger
2. DATE OF DEATH (Month, Day, Year): May 18, 1989
3. TIME OF DEATH: 8:00 P. M
4. SOCIAL SECURITY NUMBER: 219-03-2417
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 19, 1919
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 129 Drexel Drive
9b. CITY, TOWN OR LOCATION OF DEATH: Millersville
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Millersville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 129 Drexel Drive
10f. ZIP CODE: 21108
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW 2
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES [XX] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Engineer
16b. KIND OF BUSINESS/INDUSTRY: Chem Metals

17. FATHER'S NAME (First, Middle, Last): Francis A. Kellenberger
18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen G. Knauff

19a. INFORMANT'S NAME (Type/Print): Genevieve Kellenberger
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 129 Drexel Dr., Millersville, MD 21108

20a. METHOD OF DISPOSITION: [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park
20c. LOCATION — City or Town, State: Glen Burnie, A.A., MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home, 421 Crain Hwy. S.E., Glen Burnie, MD 21061

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Carcinoma of Colon | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ May 18, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4016 Ritchie Hwy Baltimore MD-21225
31. DATE FILED (Month, Day, Year): MAY 24 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12979

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elsie M King
2. DATE OF DEATH (Month, Day, Year): 5 17 89
3. TIME OF DEATH: 5:53 PM
4. SOCIAL SECURITY NUMBER: 218-07-9804
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-17-1896
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Meridian Hammonds Lane
9b. CITY, TOWN OR LOCATION OF DEATH: Brooklyn Park
9c. COUNTY OF DEATH: A-A County

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: A-A
10c. CITY, TOWN OR LOCATION: Linthicum
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 907 Wanda Rd
10f. ZIP CODE: 21090
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPAHIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed&Owner
16b. KIND OF BUSINESS/INDUSTRY: Sea Food
17. FATHER'S NAME (First, Middle, Last): Edward Geoghegan
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret L. McGlone
19a. INFORMANT'S NAME (Type/Print): Ethel H. Walsh
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 907 Wanda Road Linthicum, Maryland 21090
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Zgamiowski
22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.
DUE TO (OR AS A CONSEQUENCE OF):
b. ATRIAL FIBRILLATION
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE.
DUE TO (OR AS A CONSEQUENCE OF):
d. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.
SENILE DEMENTIA.

24a. WAS AH AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ HO
24b. WERE AUTOPSY FIHDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ HO
25. WAS CASE REFERRED TO MEDICAL EXAMIHER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANHER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF IHJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ HO
28d. DESCRIBE HOW IHJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AHD TITLE OF CERTIFIER: Harvit Singh MD Attending Physician
29c. LICEHSE HUMBER: D 14160
29d. DATE SIGHED (Month, Day, Year): ▶ 5/18/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): HARVIT SINGH. 5507-E RITCHIE HIGHWAY, BALTIMORE Md. 21225
31. DATE FILED (Month, Day, Year): MAY 22 1989
32. REGISTRAR'S SIGHATURE: Julia Dinkins Reddick

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12980

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert Lohman | | | 2. DATE OF DEATH (Month, Day, Year): May 16, 1989 | 3. TIME OF DEATH: 12:30 A M |
| 4. SOCIAL SECURITY NUMBER: 216- 18- 5269 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 18, 1909 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel Co. |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Edgewater | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 436 Walnut Dr. | | 10f. ZIP CODE: 21037 | | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic | | 16b. KIND OF BUSINESS/INDUSTRY: Auto Industry | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Alburtus Lohman | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Shafer | | |
| 19a. INFORMANT'S NAME (Type/Print): Doris D. Lohman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 436 Walnut Dr., Edgewater, Md. 21037 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mountain View Cemetery | 20c. LOCATION — City or Town, State: Sharpsburg, Wash. Co., Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John H. Bast, Jr. | 22. NAME AND ADDRESS OF FACILITY: Bast Funeral Home, 7606 Boonsboro Pike, Boonsboro, Md. 21713 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiorespiratory arrest | 10 minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Metastatic squamous cell lung cancer | 30 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: D32349

29d. DATE SIGNED (Month, Day, Year): ▶ 5/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Gregory S. Neilley 134 Owensville Road West River MD 20778

31. DATE FILED (Month, Day, Year): MAY 19 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

89 12981

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Matthew Eric Lukeski | | 2. DATE OF DEATH (Month, Day, Year): May 14, 1989 | 3. TIME OF DEATH: 1:45 P.M. |
| 4. SOCIAL SECURITY NUMBER: 214.04.1287 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 16 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 28, 1972 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 327 New Jersey Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 327 New Jersey Avenue | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: High School | |
| 17. FATHER'S NAME (First, Middle, Last): Francis T. Lukeski | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sheila M. Woodward | | |
| 19a. INFORMANT'S NAME (Type/Print): Sheila M. Lukeski | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Brooklyn Park, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold B Pinson | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | BRAIN STEM HERNIATION | 1 DAY |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | BRAIN TUMOR (GLIOBLASTOMA) | 9 MOS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Allen D. Schwartz, M.D. | 29c. LICENSE NUMBER: D10270 | 29d. DATE SIGNED (Month, Day, Year): 5/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALLEN D. SCHWARTZ, M.D. SINAI HOSPITAL BALTO. MD. 21215 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rendeiro | |

DHMH-15 Rev 1/89

89 1298I

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12982

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): IDA (NMN) LOO | | | | 2. DATE OF DEATH (Month, Day, Year): 05 05 89 | 3. TIME OF DEATH: 146 AM M |
| 4. SOCIAL SECURITY NUMBER: 331-28-6260 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 05-21-09 | 8. BIRTHPLACE (State or Foreign Country): Estonia |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: 7843 | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7843 Americana Circle | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: Estonia |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Production Line | 16b. KIND OF BUSINESS/INDUSTRY: Manufacturing |
| 17. FATHER'S NAME (First, Middle, Last): Gustav Ottas | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Hermann |
| 19a. INFORMANT'S NAME (Type/Print): Maila Koiva | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 693 Dill Road, Severna Park 21146 |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc. | 20c. LOCATION — City or Town, State: Catonsville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ George E. [illegible] | 22. NAME AND ADDRESS OF FACILITY: Cremation Society of MD Baltimore, MD 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Gangrene of small intestine DUE TO (OR AS A CONSEQUENCE OF): | 24 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. | Sepsis DUE TO (OR AS A CONSEQUENCE OF): | |
| c. | Renal Failure DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: U. Rao Sunkara M.D. | 29c. LICENSE NUMBER: D21187 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 23 (Type/Print): U. RAO SUNKARA, M.D. 14 WELLHAM AVENUE, SUITE 203 GLEN BURNIE, MARYLAND 21061

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12983

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HOMER LEE
2. DATE OF DEATH (Month, Day, Year): 04-22-89
3. TIME OF DEATH: 0402 A M
4. SOCIAL SECURITY NUMBER: 2
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/14/1910
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS
9c. COUNTY OF DEATH: AA CO.

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Queen Anne's
10c. CITY, TOWN OR LOCATION: Chester
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: Dominion Road
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? U.S
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WATERMAN
16b. KIND OF BUSINESS/INDUSTRY: Sea Food
17. FATHER'S NAME (First, Middle, Last): Richard Lee
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA Lee
19a. INFORMANT'S NAME (Type/Print): Ruby Bansley Alexander
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Chester Md.
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): April 26, 1989
20c. LOCATION — City or Town, State: Chester Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eric Dashiell 574
22. NAME AND ADDRESS OF FACILITY: 322 E AVE Easton Md

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Bleed — Days

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF OEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. OESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James Chaconas M.D
29c. LICENSE NUMBER: D16964
29d. DATE SIGNED (Month, Day, Year): ▶ 4/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Chaconas 1509 Ritchie Hwy Arnold Md 21012
31. DATE FILED (Month, Day, Year): APR 27 '89
32. REGISTRAR'S SIGNATURE: Lia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12984

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| HENRY | IRVING | MILLER | 05 06 89 | 1155 AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213 16 5453 | 1 X M 2 ☐ F | 79 YRS. | | | July 15, 1909 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Pasadena | 1 ☐ YES 2 X NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1658 Cornfield Rd. | 21122 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: W W II | 1 ☐ YES 2 X NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | Supervisor/ Group Lder. | Anne Arundel Countay Government |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Henry C. Miller | Margaret Marsh |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary V. Miller | 1658 Cornfield Rd., Pasadena, Maryland 21122 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Parkwood Cemetery | Parkville, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Stephen D. Johnson | McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, Maryland 21122 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebrouascular accident minutes. | minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Auricular flutter- fibrillation DUE TO (OR AS A CONSEQUENCE OF): | 1 year |
| | c. Coronary Artery disease DUE TO (OR AS A CONSEQUENCE OF): | 10 years |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pagets disease

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☑ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) HOME |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Irwin Moss, M.D. | DO 7036 | ▶ May 8, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
IRWIN MOSS, M.D. 11065 LITTLE PATUXENT PARKWAY-101 COLUMBIA, MARYLAND 21044

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 8 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 12985

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12985

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MIRIAM T. MYERS | 2. DATE OF DEATH (Month, Day, Year): 05 01 89 | 3. TIME OF DEATH: 4:03 P M | |
| 4. SOCIAL SECURITY NUMBER: 219-12-8218 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): 09 25 20 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | |
| 9a. FACILITY NAME (If not institution, give street and number): 301 LORI DRIVE APT.H 21061 | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: GLEN BURNIE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 301 LORI DRIVE APT.H | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PACKER | 16b. KIND OF BUSINESS/INDUSTRY: FOOD MANUFACTURING | |
| 17. FATHER'S NAME (First, Middle, Last): BARNEY SCHWARTZ | 18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA SNYDERMAN | | |
| 19a. INFORMANT'S NAME (Type/Print): WILLIAM T.MYERS III | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 633 SEAN DR. ANNAPOLIS, MARYLAND 21401 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND VETERANS CEMETERY | 20c. LOCATION — City or Town, State: CROWNSVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Raymond C. Kaufman | 22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W. GLEN BURNIE, MD. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE Myocardial INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSCLEROTIC VASCULAR HEART DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. With ANGINA PECTORIS - | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS TYPE II

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO: N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO: N/A | 28d. DESCRIBE HOW INJURY OCCURED: N/A |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: DO 4809 | 29d. DATE SIGNED (Month, Day, Year): ▶ 05 02 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BENITO MARTINEZ M.D. 2932 MOUNTAIN ROAD PASADENA, MARYLAND 21122

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 2, 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12986 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERTHA MILLER | | | 2. DATE OF DEATH (Month, Day, Year): 5 7 89 | 3. TIME OF DEATH: 2:40 P.M. M |
| 4. SOCIAL SECURITY NUMBER: 218-18-6452 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-14-16 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 102 Emerson Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Ferndale | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Ferndale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 102 Emerson Avenue | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: own home | |
| 17. FATHER'S NAME (First, Middle, Last): Francis J. Braun | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha McLaughlin | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph J. Braun | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3133 Stafford St. Baltimore, MD 21229 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute myocardial infarction | 1 hr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic cardiovascular disease | 5 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen K. Padussis MD | 29c. LICENSE NUMBER: D09405 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-8-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Padussis, Dr. Stephen K. 3455 Wilkens Avenue Suite 305 | | |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

OHMH-18 Rev 1/89

89 1298

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12987

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Peter A. Medhurst | | | | 2. DATE OF DEATH (Month, Day, Year): 05-12-89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 221-22-2013 | 5. SEX: XX 1 M 2 F | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-22-18 | 8. BIRTHPLACE (State or Foreign Country): England |
| 9a. FACILITY NAME (If not institution, give street and number): 4744 L. Flanders Lane | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Harwood | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: AA | 10c. CITY, TOWN OR LOCATION: Harwood | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4744 L. Flanders Lane | | 10f. ZIP CODE: 20776 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Salesman | 16b. KIND OF BUSINESS/INDUSTRY: Liquor |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Archibald W. Medhurst | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eileen Edith Perry |
| 19a. INFORMANT'S NAME (Type/Print): Margaret B. Medhurst | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4744 L. Flanders Lane, Harwood, MD 20776 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Crematory | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul J. Hardesty | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home 905 Galesville Rd, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | COPD | 10 years |
| DUE TO (OR AS A CONSEQUENCE OF): | Cigarette Use | 35 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

essential thrombocythemia
ASCVD

| | |
|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stuart E. Selonick, MD | 29c. LICENSE NUMBER: 019838 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stuart Selonick, MD, 51 Franklin Street, Annapolis, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 16 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12988
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PAUL MURRAY | | | 2. DATE OF DEATH (Month, Day, Year): April 18, '89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218-18-6747 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/29/23 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 8435 Arbutus Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Pasadena | | 9c. COUNTY OF DEATH: A.A. |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: A.A. | 10c. CITY, TOWN OR LOCATION: Pasadena | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8435 Arbutus Road | | 10f. ZIP CODE: 21122 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | | 16b. KIND OF BUSINESS/INDUSTRY: Railroad |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Paul Murray | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cecilia Mobley | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Lou Myers | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8538 Main Ave. Rivier Beach, Md. 21122 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | | 20c. LOCATION — City or Town, State: Glen Burnie, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Franciewicz | | 22. NAME AND ADDRESS OF FACILITY: GONCE FUNERAL HOME, P.A. 4001 Ritchie Hy., Baltimore, MD 21225 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Atherosclerotic Cardiovascular disease or Sudden Death | minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial infarction Arteriosclerotic Heart | 1 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Congestive Heart Failure | 1 year |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Thrombus.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 6/18/89 | 28b. TIME OF INJURY: 3:15 PM | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael Garahy | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Garahy, M.D. 8651 Ft. Smallwood Rd., Pasadena, MD. 21122

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12989
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| WILLIAM | H | MARSH SR | 05 / 29 / 89 | 1034 PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-16-9441 | 1 [X] M 2 [ ] F | 65 YRS. | | | July 24, 1923 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | A.A. County | Glen Burnie | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 112 2nd Avenue | 21061 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. II | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| Unknown | | Main Machinist | Koppers Co. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William Henry Marsh | Violet Gibbons |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Barbara J. Roemer | 126 Glen Road, Glen Burnie MD 21061 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill Cemetery | Baltimore, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Robert Gregory Brehm | Kirkley Funeral Home 421 Crain Hwy. S.E. Glen Burnie, Maryland 21061 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular fibrillation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ischemic Cardiomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus
Dilated Cardiomyopathy
COPD

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | N.A. | N.A. M | 1 [ ] YES 2 [X] NO | N.A. |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| N.A. | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| J. Presbitero, M.D. | D16208 | ▶ 6/1/89 |

30. NAME, ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item(s) 23) (Type or Print)
JOSE M. PRESBITERO, M.D. 7845 OAKWOOD ROAD #107 GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| JUN 01 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 12990
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ~~Howard~~ Grace Anna Nowak | | | 2. DATE OF DEATH: MONTH 5 DAY 18 YEAR 89 | 3. TIME OF DEATH: 7:42PM M |
| 4. SOCIAL SECURITY NUMBER: * * * * * * * | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): YRS. | IF UNDER 1 YEAR: MONTHS 9 DAYS 9 / IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): Aug 9, 1988 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1700 Green Tree Court | 9b. CITY, TOWN OR LOCATION OF DEATH: Crofton | 9c. COUNTY OF DEATH: Ann Arundel | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Ann Arundel | 10c. CITY, TOWN OR LOCATION: Crofton | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1700 Green Tree Court | 10f. ZIP CODE: 21114 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): * * * * * * College (1-4 or 5+): * * * * * | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): * * * * * * * * * * | 16b. KIND OF BUSINESS/INDUSTRY: * * * * * * * * * * |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Mark Nowak | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marla Gaines |
| 19a. INFORMANT'S NAME (Type/Print): Mark Nowak | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1700 Green Treet Ct., Crofton, Md. 21114 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Horeb Ch. Cemetery | 20c. LOCATION — City or Town, State: Hinton, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Kyger & Trobaugh Funeral Home Harrisonburg, Virginia 22801 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pulmonary alveolar proteinosis | 45+ mos |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: 036032 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steven F. Brown 9811 Mallard Drive, Suite 119 Laurel MD | | |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12991

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CORA C. NELSON
2. DATE OF DEATH (Month, Day, Year): 5/1/89
3. TIME OF DEATH: 9 a.m.
4. SOCIAL SECURITY NUMBER: 236 14 6585
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb 27, 1905
8. BIRTHPLACE (State or Foreign Country): W.Va.
9a. FACILITY NAME (If not institution, give street and number): Maryland Manor Conv. Ct.
9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Glen Burnie
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7575 East Howard Rd.
10f. ZIP CODE: 21061
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: HOME
17. FATHER'S NAME (First, Middle, Last): Jacob K. Armentrout
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie Paxton
19a. INFORMANT'S NAME (Type/Print): Clarence Brown
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 354 Severn, Md. 21144
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Queens Point
20c. LOCATION — City or Town, State: Keyser, W.Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allen M. Rotruck
22. NAME AND ADDRESS OF FACILITY: Rotruck Funeral Home, 85 S.Main St. Keyser, W.Va. 26726

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use by the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.
DUE TO (OR AS A CONSEQUENCE OF):
c. ANAEMIA
DUE TO (OR AS A CONSEQUENCE OF):
d. SENILE DEMENTIA.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Harjit Singh MD Attending Physician
29c. LICENSE NUMBER: D14160
29d. DATE SIGNED (Month, Day, Year): ▶ 05/01/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): HARJIT SINGH MD. 5507-E RITCHIE HWY., 21225. Md.
31. DATE FILED (Month, Day, Year): MAY 4 - 1989
32. REGISTRAR'S SIGNATURE

3

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12992 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ETTA M NIELSEN | | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 15 / 89 | 3. TIME OF DEATH: 5.30 AM M |
| 4. SOCIAL SECURITY NUMBER: 212 05 1594 | 5. SEX: 1 ☐ M 2 XX F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | | 7. DATE OF BIRTH (Month, Day, Year): Jan. 4, 1906 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 514 Oak Rd. | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Telephone Operator | 16b. KIND OF BUSINESS/INDUSTRY: Telephone Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Frank Devine | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Bergner | |
| 19a. INFORMANT'S NAME (Type/Print): Norman E. Burns | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 Oak Rd., Pasadena, Maryland 21122 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Schumann | | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena, 3204 Mountain Rd., Pasadena, MD 21122 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Mitral Valve Insufficiency | 2 years |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Myocardial Infarction | 1/2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Atherosclerosis | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Recent Surgeries for Pseudoaneurysms of both Femoral arteries

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Ehrlich MD | 29c. LICENSE NUMBER: D02519 | 29d. DATE SIGNED (Month, Day, Year): ▶ May 15 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 420 S. CRAIN HIGHWAY, SUITE 3 GLEN BURNIE, MARYLAND 21061 | | |
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill | |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12993

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DELLA MAY OCHS | | | | | 2. DATE OF DEATH: MONTH 05 DAY 22 YEAR 89 | 3. TIME OF DEATH: 0230 AM M |
| 4. SOCIAL SECURITY NUMBER: 212 22 3175 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 2, 1926 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Bunrie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7853 Crilly Rd. | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Domestic | |
| 17. FATHER'S NAME (First, Middle, Last): (Unknown) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Della Monroe | |
| 19a. INFORMANT'S NAME (Type/Print): Francis H. Ochs | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Locust Dr., Baltimore, Maryland 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steph D. Lehmann | 22. NAME AND ADDRESS OF FACILITY: McCully FuneralHome of Pasadena 3204 Mountian Rd., Pasadena, MD 21122 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Carcinoma, metastatic to bone & brain
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Non-Small Cell Carcinoma of Lung
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Right hemiparesis due to Carcinoma
Multiple Sensory Deprivation

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|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Richard E. Fisher MD | 29c. LICENSE NUMBER: DO 2519 | 29d. DATE SIGNED (Month, Day, Year) ▶ 22-May-89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD E. FISHER, M.D. 420 CRAIN HIGHWAY, SUITE 3 GLEN BURNIE, MARYLAND 21061 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsey | | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12994

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET RITA PEARCE | | | | | 2. DATE OF DEATH (Month, Day, Year): May 19 1989 | 3. TIME OF DEATH: 1054 AM M |
| 4. SOCIAL SECURITY NUMBER: 218.36.0404 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 19, 1916 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 317 Oak Manor Drive, Apt T3 | | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4 or 8+): None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: - | |
| 17. FATHER'S NAME (First, Middle, Last): George Schaechtel | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Brickman | | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert M. Pearce | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 317 Oak Manor Drive Apt T3, Glen Burnie, Md.21061 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gdns. | | 20c. LOCATION — City or Town, State: Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md.21061 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Septicemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHF (Congestive Heart Failure) Carcinoma of Vulva

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | MD 36900 | ▶ 5/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27: KRISHNA R. SINGAL, M.D. 722 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MD. 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 23 1989 | Julia Davidson-Rendeiro |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12995 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ELISE PARKER

**2. DATE OF DEATH** (Month, Day, Year): 5 16 1989

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**:

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 67 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.:

**7. DATE OF BIRTH** (Month, Day, Year): 3 2 1922

**8. BIRTHPLACE** (State or Foreign Country): MARYLAND

**9a. FACILITY NAME** (If not institution, give street and number): A.A. MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: Annapolis

**9c. COUNTY OF DEATH**: Anne Arundel

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**: ANNE ARUNDEL

**10c. CITY, TOWN OR LOCATION**: ANNAPOLIS

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 1145 Madison Street

**10f. ZIP CODE**: 21403

**10g. CITIZEN OF WHAT COUNTRY?**: u.s.a.

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: BLACK

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): ELEMENTARY; College (1-4 or 8+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): JOSEPH SIMMS

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): MARTHA PARKER

**19a. INFORMANT'S NAME** (Type/Print): JAMES DOWNS

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 Garden Gate Lane Annapolis, Md. 21403

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): HILL CREST CEMETERY

**20c. LOCATION — City or Town, State**: ANNAPOLIS, MARYLAND

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Larry G. Reese

**22. NAME AND ADDRESS OF FACILITY**: 821 West Street WM. REESE & SONS MORTUARY, P.A. ANNAPOLIS, MD.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART i.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIO PULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):
b. ASPIRATION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. CEREBRO VASCULAR ACCIDENT

DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART ii.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ ~~NO~~

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one):
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: PRINTED DOCTOR

**29c. LICENSE NUMBER**: D21684

**29d. DATE SIGNED** (Month, Day, Year): 5.22.89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): C.V. CYRIAC M.D 14 WELLHAM AVE N.W. GLENBURNIE MD 21061

**31. DATE FILED** (Month, Day, Year): MAY 22 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Rudasill

DHMH-16 Rev 1/89

89 1995

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 12996
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page [illegible], 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Louis Benjamin Richardson | | | | 2. DATE OF DEATH: MONTH 5 DAY 2 YEAR 89 | 3. TIME OF DEATH: 7:08PM M |
| 4. SOCIAL SECURITY NUMBER: 578-09-9545 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 06-30-09 |
| 8. BIRTHPLACE (State or Foreign Country): Washington D.C. | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 478 West Central Avenue | 9b. CITY, TOWN OR LOCATION OF DEATH: Davidsonville | 9c. COUNTY OF DEATH: Anne Arundel Co. | | | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Davidsonville, | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | | |
| 10e. STREET AND NUMBER: 478 W. Central Avenue | 10f. ZIP CODE: 21035 | 10g. CITIZEN OF WHAT COUNTRY? USA | | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer | 16b. KIND OF BUSINESS/INDUSTRY: Printing/Newspaper | | | |
| 17. FATHER'S NAME (First, Middle, Last): William Richardson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Tennely | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Evangeline M. Richardson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 478 W. Central Avenue, Davidsonville, MD | | | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): All Hollows Cemetery | 20c. LOCATION — City or Town, State: Birdsville, MD | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Patrick J. Gilbert | 22. NAME AND ADDRESS OF FACILITY: 12 Ridgely Avenue Annapolis, MD 21401 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory srrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wound of head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 5-2-89 | 7:08P M | 1 [ ] YES [X] NO | self inflicted |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home-driveway

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 478 West Central Avenue, Davidsonville, Anne Arundel County, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr. M.D.

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 5-3-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 vc

31. DATE FILED (Month, Day, Year): MAY 04 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

12
85

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 12997

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thomas A. Rowan | | | 2. DATE OF DEATH (Month, Day, Year): May 6, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218 22 2143 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year): August 23, '28 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 202 Kennedy Dr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Severna Park | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 202 Kennedy Dr. | | 10f. ZIP CODE: 21146 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W W II, Korean Con. | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY: Transit Company | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas George Rowan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Morning | |
| 19a. INFORMANT'S NAME (Type/Print): Martha L. Rowan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 Kennedy Dr., Severna Park, MD 21146 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc. | 20c. LOCATION — City or Town, State: Catonsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Shumm | | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena, 3204 Mountain Rd., Pasadena, MD 21122 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adenocarcinoma of the stomach | 12/21/84 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. D. | 29c. LICENSE NUMBER: D 10574 | 29d. DATE SIGNED (Month, Day, Year): ▶ May 8, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Manuel Sanchez, M.D. 1424 Sulphur Spring Road, Baltimore, Md. 21227

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12998

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rosa Roszel Ruckner
2. DATE OF DEATH — MONTH: 5 DAY: 2 YEAR: 89
3. TIME OF DEATH: 9:20P M
4. SOCIAL SECURITY NUMBER: 220209872
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 8, 1910
8. BIRTHPLACE (State or Foreign Country): Wash., D.C.
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: MD.
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1913 Sleepy Hollow Lane
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: NA
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. OCCEOFNT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): John McGill
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Earle Roszel
19a. INFORMANT'S NAME (Type/Print): Edward A. Ruckner
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1913 Sleepy Hollow Lane, Annapolis, MD. 21401
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): U.S. Naval Academy Cemetery
20c. LOCATION — City or Town, State: Annapolis, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffry L. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel, Annapolis, MD.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cerebrovascular Accident | 10 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Peripheral Vascular Disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Intestinal Pneumonia with Respiratory Failure | 2 wks |
| DUE TO (OR AS A CONSEQUENCE OF): d. | Congestive Heart Failure | years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Anemia
COPD
Chronic Dehydration

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Colgan
29c. LICENSE NUMBER: D3118 8
29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD COLGAN 703 Giddings Ave. Annapolis MD 21402
31. DATE FILED (Month, Day, Year): MAY 04 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 12999

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Ira Lee Robinson
2. DATE OF OEATH (Month, Day, Year): May 17, 1989
3. TIME OF OEATH: M
4. SOCIAL SECURITY NUMBER: 224.01.2035
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 22, 1908
8. BIRTHPLACE (State or Foreign Country): Tennessee
9a. FACILITY NAME (If not institution, give street and number): 716 Oser Drive
9b. CITY, TOWN OR LOCATION OF DEATH: Crownsville
9c. COUNTY OF OEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Crownsville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 716 Oser Drive
10f. ZIP CODE: 21032
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR OATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tool & Dye Maker
16b. KIND OF BUSINESS/INDUSTRY: Great Lake Steel(Steelmill)
17. FATHER'S NAME (First, Middle, Last): George Robinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eliza Savaze
19a. INFORMANT'S NAME (Type/Print): Lucy Gambrill
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 716 Oser Drive, Crownsville, Md. 21032
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Roselawn Memorial Park And Mausoleum
20c. LOCATION — City or Town, State: LaSalle, Michigan
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold B. Pusey
22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | NON-HODGKIN'S Lymphoma | 3 YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| OUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF OEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. OESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard S. Kaplan MD
29c. LICENSE NUMBER: D23827
29d. OATE SIGNED (Month, Day, Year): 5/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard S. Kaplan MD 22 S. Greene St. Baltimore, MD 21201
31. DATE FILED (Month, Day, Year): MAY 19 1989
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

89 13000

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDWARD LEROY RECKARD, Jr. | | | 2. DATE OF DEATH (Month, Day, Year): May 21 1989 | 3. TIME OF DEATH: 0825 AM M |
| 4. SOCIAL SECURITY NUMBER: 217.34.7342 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 50 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): July 21, 1938 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Millersville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8382 Elm Road | | 10f. ZIP CODE: 21108 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Selector | 16b. KIND OF BUSINESS/INDUSTRY: Grocery |
| 17. FATHER'S NAME (First, Middle, Last): Edward L. Reckard, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Mosmiller | |
| 19a. INFORMANT'S NAME (Type/Print): Jack J. Stembler | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1318 Maple Avenue, Arbutus, Md.21227 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md.21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | IMMED. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MYOCARDIAL INFARCTION | IMMED. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CORONARY ATHEROSCLEROSIS | 10 YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO N/A |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: — M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: N/A | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Leon C Perry MD FAM. PHYSICIAN | 29c. LICENSE NUMBER: D 09416 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-24-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type or Print): DR. LEON PERRY SUITE 201, 325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061 | | |
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

88 13000

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13001

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE F. RUSH Jr. | | | 2. DATE OF DEATH: MONTH 5 DAY 18 YEAR 89 | 3. TIME OF DEATH: NOON M |
| 4. SOCIAL SECURITY NUMBER: 214-01-4953 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/16/08 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 183 11th Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Pasadena | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 183 11th Street | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner | 16b. KIND OF BUSINESS/INDUSTRY: Trucking Firm | |
| 17. FATHER'S NAME (First, Middle, Last): George F. Rush Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie E. Eberling | |
| 19a. INFORMANT'S NAME (Type/Print): Marie Beck | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 183 11th Street Pasadena, Maryland 21122 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Richard Gonce | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE CORONARY INSUFFICIENCY

DUE TO (OR AS A CONSEQUENCE OF):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. TOBACCO USE

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
EMPHYSEMA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] OOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D33757 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-19-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 108 ASKEWTON ROAD SV MD 21146. | | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dearborn-Kendall | |

DNMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13002 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Beatnce F. Scheff — BEATRICE FLORENCE SCHEFF | | | 2. DATE OF DEATN (Month / Day / Year): 5 / 9 / 89 | 3. TIME OF DEATN: 12:40p M |
| 4. SOCIAL SECURITY NUMBER: 105-18-3571 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 82 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTN (Month, Day, Year): 6-29-06 | 8. BIRTNPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): MARYLAND MANOR NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATN: GLEN BURNIE | | 9c. COUNTY OF DEATN: ANNE ARUNEDL |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: GLEN BURNIE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1303 GILBERT PLACE | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATNER'S NAME (First, Middle, Last): HENRY WEIL | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): BERTHA UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. MARILYN BREWER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1303 GILBERT PLA., GLEN BURNIE, MD 21061 | |
| 20a. METNOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BNAI ISRAEL | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CONGESTIVE HEART FAILURE.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
b. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE.
DUE TO (OR AS A CONSEQUENCE OF):
c. CEREBRO-VASCULAR ACCIDENT
DUE TO (OR AS A CONSEQUENCE OF):
d. SENILE DEMENTIA.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE. HIATAL HERNIA.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF OEATN (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF OEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Nomicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. OESCRIBE NOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYINO PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harjit Singh MD Attending Physician | 29c. LICENSE NUMBER: D 14160 | 29d. DATE SIGNED (Month, Day, Year): 05/9/89 | |
| 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print): HARJIT SINGH-M.D. 5507-E RITCHIE HIGHWAY, BALTIMORE Md. 21225 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau | | |

DNMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13003

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDWARD GEORGE SCHRAMEK | | | 2. DATE OF DEATH (Month, Day, Year): 05 05 89 | 3. TIME OF DEATH: 445 AM M |
| 4. SOCIAL SECURITY NUMBER: 217 03 2909 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 22, 1911 | 8. BIRTHPLACE (State or Foreign Country): Maryland |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3 Bon Air Rd. | | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): | 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder | 16b. KINO OF BUSINESS/INOUSTRY: Oil Company |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): John Schramek | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine (Unknown) |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print): Ruth S. Schramek | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Bon Air Rd., Baltimore, MD 21225 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Schmuser | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Baltimore, MD 21225 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBROVASCULAR ACCIDENT | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): CARCINOMA OF LUNG | 1½ years |
| | c. DUE TO (OR AS A CONSEQUENCE OF): CHRONIC OBSTRUCTIVE PULMONARY DISEASE | 10 years |
| | d. DUE TO (OR AS A CONSEQUENCE OF): ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE | 5 years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ESSENTIAL HYPERTENSION

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harjit Singh MD Attending Physician | 29c. LICENSE NUMBER: D14160 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/5/89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5507-E RITCHIE HIGHWAY BALTIMORE, MARYLAND 21225 HARJIT SINGH M.D.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: James Burdette |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13004

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Mae Swain
2. DATE OF DEATH (Month, Day, Year): May 7, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 498.05.3987
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 8, 1921
8. BIRTHPLACE (State or Foreign Country): Iowa
9a. FACILITY NAME (If not institution, give street and number): 410 Starwood Drive Apt A
9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Glen Burnie
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 410 Starwood Drive Apt A
10f. ZIP CODE: 21061
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 — College (1-4 or 5 +): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed
16b. KIND OF BUSINESS/INDUSTRY: Musical
17. FATHER'S NAME (First, Middle, Last): Chester Treece
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Breznik
19a. INFORMANT'S NAME (Type/Print): Mrs. Linda E. Pastoor
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20435 Slabbridge Road, Freeland, Md. 21053
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park
20c. LOCATION — City or Town, State: Glen Burnie, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H B Wilson
22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md.21061

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic Anal carcinoma — 1½ yr
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Long S. Hsu M.D.
29c. LICENSE NUMBER: D20431
29d. DATE SIGNED (Month, Day, Year): ▶ 5/8/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Long S. Hsu, M.D. 300 Hospital Drive S.230 Glen Burnie Md. 21061
31. DATE FILED (Month, Day, Year): MAY 9 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13005

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAISY LEE SCOTT
2. DATE OF DEATH (Month, Day, Year): 5 - 8 - 89
3. TIME OF DEATH: 9:47 A M
4. SOCIAL SECURITY NUMBER: 219-28-0060
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/25/32
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS, MD
9c. COUNTY OF DEATH: AACO

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10a. STREET AND NUMBER: 1031 BOUCHER AVENUE
10f. ZIP CODE: 21203
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): CLEVELAND GRAVES
18. MOTHER'S NAME (First, Middle, Maiden Surname): GRACE NATER
19a. INFORMANT'S NAME (Type/Print): DON SCOTT
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1521 SHEFFIELD ROAD?BALTO., MD 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEM.
20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: end stage renal disease, peptic peripheral vascular disease, diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: GARY A MITCHELL MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 5/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 205 Riddle Ave Annapolis MD 21401
31. DATE FILED (Month, Day, Year): MAY 11 1989
32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13006

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EMMA ELIZABETH STEINHICE | | | 2. DATE OF DEATH (Month, Day, Year): 05 23 89 | 3. TIME OF DEATH: 627 PM M |
| 4. SOCIAL SECURITY NUMBER: 218-07-1493 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-15-08 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1405 Woodland Beach Road | | 10f. ZIP CODE: 21122 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Herbert A. Franklin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Karolina Utz | | |
| 19a. INFORMANT'S NAME (Type/Print): Rosemary Steinhice | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 187 Arundel Road Pasadena, Maryland 21122 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Richard Gonce | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. RESPIRATORY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CEREBROVASCULAR ACCIDENT | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | 027838 | ▶ 5/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN SHAVERS 518 S. CAMP MEAD ROAD LINTHICUM MARYLAND 21090

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 26 1989 | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89-13007 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mabel Elizabeth Saunders | | | | 2. DATE OF DEATH (Month, Day, Year): 4 15 89 | 3. TIME OF DEATH: 7:13 PM |
| 4. SOCIAL SECURITY NUMBER: 212-36-1033 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/27/04 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Annapolis Convalescent Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 44 Bloomsbury Square | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk (Sales) | 16b. KIND OF BUSINESS/INDUSTRY: Kitchens Drugstore | |
| 17. FATHER'S NAME (First, Middle, Last): E rickson Deale | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cristina Orem | |
| 19a. INFORMANT'S NAME (Type/Print): Nancy Cranmer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 44 Bloomsbury Square, Annapolis, MD | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodfield Cemetery | 20c. LOCATION — City or Town, State: Galesville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kimberly S. Rowe | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. BRAIN ANOXIA

DUE TO (OR AS A CONSEQUENCE OF):
b. CARDIO RESPIRATORY ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Atherosclerotic Cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):
d. Right CVA ⇒ (L) hemiplegia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Peripheral Vascular Disease S/P BKA Left
Congestive Heart Failure, NIDDM
Coronary Artery Disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D31997 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/16/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDREW G GORDON MD 16 Murray Ave ANNAPOLIS Md 21403 | | |
| 31. DATE FILED (Month, Day, Year): APR 17 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 13008

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Hilda (NMN) Schreiber | | | | | 2. DATE OF DEATH (Month, Day, Year): April 7, 1989 | 3. TIME OF DEATH: 7:00 AM M | |
| 4. SOCIAL SECURITY NUMBER: 213.32.9987 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): April 23, 1904 | 8. BIRTHPLACE (State or Foreign Country): Hungary | |
| 9a. FACILITY NAME (If not institution, give street and number): 102 Bertram Drive | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel | | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | | |
| 10e. STREET AND NUMBER: 102 Bertram Drive | | 10f. ZIP CODE: 21061 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+): NA | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY: NA | | |
| 17. FATHER'S NAME (First, Middle, Last): Nicholas Eszes | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia (Unknown) | | |
| 19a. INFORMANT'S NAME (Type/Print): Lillian E. Smouse | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Bliss Lane, Glen Burnie, Md. 21061 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | | | 20c. LOCATION — City or Town, State: Glen Burnie, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home #1 Second Avenue S.W. Glen Burnie, Maryland 21061 | | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or reapiratory srrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary edema

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. acute myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus
ventricular arrhythmia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James J. Benjamin

29c. LICENSE NUMBER: D0381

29d. DATE SIGNED (Month, Day, Year) ▶ 4/7/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James J. Benjamin, M.D.,653 Old Mill Road, Millersville, Maryland

31. DATE FILED (Month, Day, Year): APR 11 1989

32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 13009

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVA A SCHWARTZ | | | | 2. DATE OF DEATH (Month, Day, Year): 04 16 89 | 3. TIME OF DEATH: 0255 PM M |
| 4. SOCIAL SECURITY NUMBER: 216-169801 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | | 7. DATE OF BIRTH (Month, Day, Year): 05-20-06 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 463 Baltimore Annapolis Blvd. | | 10f. ZIP CODE: 21146 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | | 16b. KIND OF BUSINESS/INDUSTRY: Transportation | |
| 17. FATHER'S NAME (First, Middle, Last): Andrew Ostrowski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Doneski | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Walter Sosnoski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 463 Baltimore Annapolis Blvd. S.P. MD21146 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Rosary Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John A. Barranco | | 22. NAME AND ADDRESS OF FACILITY: Barranco Funeral Home 495 Ritchie Hwy. Severna Park MD21146 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Myocardial Infarction | 5 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Coronary Artery Disease | years |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1) Infarction of Myocardium 1985
2) Diabetes Mellitus 3) Hypothyroidism
4) Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Hilary T. Oherlihy MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4-17-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): HILARY T. OHERLIHY 525 HOSPITAL DRIVE, SUITE 208 GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): APR 19 1989 | 32. REGISTRAR'S SIGNATURE: Gina Lee Randall

DHMH-16 Rev 1/89

89 13010

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEWIS SCOTT | | | | | 2. DATE OF DEATH (Month, Day, Year): April 20 1989 | 3. TIME OF DEATH: 5:25 p M |
| 4. SOCIAL SECURITY NUMBER: 579 22 7955 | 5. SEX: 1 ☐ M 2 ☐ F (XX) | 6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-27-24 | 8. BIRTHPLACE (State or Foreign Country): Wash., DC |
| 9a. FACILITY NAME (If not institution, give street and number): Annapolis Convalescent Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | | 10c. CITY, TOWN OR LOCATION: Deale | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 903 Johns Circle | | | 10f. ZIP CODE: 20751 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electronic Technician | | 16b. KIND OF BUSINESS/INDUSTRY: US Gov't. | |
| 17. FATHER'S NAME (First, Middle, Last): unk. | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): unk. | | | |
| 19a. INFORMANT'S NAME (Type/Print): Marjorie Johnson | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5901 Joe Rd., Deale, MD 20751 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Southern Mem. Gardens | | 20c. LOCATION — City or Town, State: Dunkirk, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Michael Phipps RFH | | | 22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Lung Ca Metastatic → Brain | ~ 2 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Chronic Cigarette Smoking. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Harvey J Steinfeld MD | D05158 | ▶ 4/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HARVEY J STEINFELD 6131 SHADYSIDE Rd, SHADYSIDE, MD. 20764

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 26 1989 | Julia Davidson-Rhodes |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13011
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

N

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY BARBARA SCHMIER | | 2. DATE OF DEATH (Month, Day, Year): May 13, 1989 | 3. TIME OF DEATH: P M |
| 4. SOCIAL SECURITY NUMBER: 216-20-6497 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/4/21 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Crofton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1630 Eton Way | 10f. ZIP CODE: 21114 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Joseph McTaggart | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Petersen | | |
| 19a. INFORMANT'S NAME (Type/Print): Marshall Schmier | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1630 Eton Way, Crofton, MD. 21114 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan | 20c. LOCATION — City or Town, State: Alexandria, VA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey S. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel, Annapolis, MD. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBRAL THROMBOSIS OF MID BRAIN | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S. Wallman Jr MD | 29c. LICENSE NUMBER: DO 8118 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): 51 FRANKLIN ST ANNAPOLIS MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): MAY 16 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

10

89 13011

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13012 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Walter James Sears, Jr
2. DATE OF DEATH: MONTH 4 DAY 12 YEAR 89
3. TIME OF DEATH: 9:05 A M
4. SOCIAL SECURITY NUMBER: 372-09-9666
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02/08/13
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel Co

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 145 Williams Drive
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 3
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Vice-President
16b. KIND OF BUSINESS/INDUSTRY: Rubber Manufacturers Association
17. FATHER'S NAME (First, Middle, Last): Walter James Sears
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie Carpenter
19a. INFORMANT'S NAME (Type/Print): Natalie P. Sears
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 145 Williams Drive, Annapolis, MD 21401
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Anne's Cemetery
20c. LOCATION — City or Town, State: Annapolis, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clark C. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pulmonary edema | 10 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | (L) ventricular dysfunction | 4 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Coronary Atherosclerotic Heart disease | 8 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus; Sepsis.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: My Clements
29c. LICENSE NUMBER: D08314
29d. DATE SIGNED (Month, Day, Year): ▶ 4/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 205 Ridgely Ave Annapolis, MD 21401
31. DATE FILED (Month, Day, Year): APR 17 1989
32. REGISTRAR'S SIGNATURE

OHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13013
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEONARD J SEBALD SR | | | | 2. DATE OF DEATH: MONTH 04 DAY 09 YEAR 89 | 3. TIME OF DEATH: 1142 PM M |
| 4. SOCIAL SECURITY NUMBER: 218 05 0819 | 5. SEX: XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 2, 1912 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 7579 Beach Dr. | | | 10f. ZIP CODE: 21122 | | 10g. CITIZEN OF WHAT COUNTRY? United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: W W II | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): ---------- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembler | | 16b. KIND OF BUSINESS/INDUSTRY: Factory | |
| 17. FATHER'S NAME (First, Middle, Last): Peter T. Sebald | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dena M, Dobbs | | |
| 19a. INFORMANT'S NAME (Type/Print): Thelma E. Sebald | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7579 Beach Dr. Pasadena, MD 21122 | | |
| 20a. METHOD OF DISPOSITION: XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Lohmeier | | | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd. Pasadena, MD 21122 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma-lung.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XX NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 XX NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Michael Gunsalus Physician | D19667 | ▶ 4/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 23 (Type, Print): MICHAEL SCHMARTZ 600 RAYMONDS LANE BALTIMORE, MD 21225

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 11 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

SCB 11

89 13014

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NATHENIA ELIZABETH SELETZKY | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 11 / 1989 | 3. TIME OF DEATH: 6:00 p M |
| 4. SOCIAL SECURITY NUMBER: 212-09-3006 A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (If yrs. last birthday): 75 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 01/12/1914 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 110 Giddings Ave. | 10f. ZIP CODE: 21146 | | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian | 16b. KIND OF BUSINESS/INDUSTRY: Educational Institutions |
| 17. FATHER'S NAME (First, Middle, Last): Richard Preece | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sue Gilbert | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Dimitri Seletzky | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Giddings Ave. Severna Park, MD 21146 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Park Heights, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John A. Barranco | | 22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Highway Barranco Funeral Home-Severna Park, MD21146 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | cardiac arrest | min |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | chronic congestive heart failure | yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure
chronic obstructive pulm. disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: GH Mitchell MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 205 Ridgely Ave Annapolis MD 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 18 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Landers |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13015
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): HAROLD E. SEMLER

**2. DATE OF DEATH** Month: 4 Day: 19 Year: 89

**3. TIME OF DEATH**: 1120 A.M. M

**4. SOCIAL SECURITY NUMBER**: 509-12-3489

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 6/10/20

**8. BIRTHPLACE** (State or Foreign Country): Oklahoma

**9a. FACILITY NAME** (If not institution, give street and number): North Arundel Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Glen Burnie

**9c. COUNTY OF DEATH**: Anne Arundel

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Anne Arundel

**10c. CITY, TOWN OR LOCATION**: Pasadena

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 110 Mulberry Avenue

**10f. ZIP CODE**: 21122

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS** 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW II

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 2yrs College

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Inspector

**16b. KIND OF BUSINESS/INDUSTRY**: Tab. ALC-FH

**17. FATHER'S NAME** (First, Middle, Last): Philip E. Semler

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Gladys Gray

**19a. INFORMANT'S NAME** (Type/Print): Marlene Semler

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Mulberry Ave. Pasadena, Md. 21122

**20a. METHOD OF DISPOSITION** 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Glen Haven Memorial Park

**20c. LOCATION — City or Town, State**: Glenn Burnie, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE** ▶ Teresa L Hott

**22. NAME AND ADDRESS OF FACILITY**: Hubbard Funeral Home, Inc.
4107 Wilkens Avenue Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Pancreas Cancer | 6 month |
| DUE TO (OR AS A CONSEQUENCE OF): b. | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH** 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Elliott Gorbaty

**29c. LICENSE NUMBER**: D20094

**29d. DATE SIGNED** (Month, Day, Year) ▶ 04/19/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type/Print): ELLIOTT GORBATY, M.D. 7845 OAKWOOD ROAD, SUITE 203 GLEN BURNIE, MARYLAND 21061

**31. DATE FILED** (Month, Day, Year): APR 21 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 13016

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CALVIN SHIPLEY SHILLING
2. DATE OF DEATH (Month, Day, Year): 04 05 89
3. TIME OF DEATH: 1254 PM
4. SOCIAL SECURITY NUMBER: 219-07-4008
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/13/18
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL — RESIDENCE OF DECEDENT
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: A.A. COUNTY
10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Riviera Beach
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ ND
10e. STREET AND NUMBER: 8479 Ft. Smallwood Road
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: World War II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed
16b. KIND OF BUSINESS/INDUSTRY: Septic Systems
17. FATHER'S NAME (First, Middle, Last): Charles Shilling
18. MOTHER'S NAME (First, Middle, Maiden Surname): Iva Shipley
19a. INFORMANT'S NAME (Type/Print): Helen Jean Shilling
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8479 Ft. Smallwood Rd. Riviera Beach, Md.21122
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Richard Gonce
22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction — Approx. Interval: < 1 Day

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Coronary Artery Heart Disease — Approx. Interval: Years

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ND

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Hilary T O'Herlihy MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 4-5-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HILARY T O'HERLIHY M.D. / 325 HOSPITAL DRIVE SUITE 208 GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year)
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

89 13017

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Clara Elsie Shubkagel | | | 2. DATE OF DEATH: Month April Day 10 Year 89 | 3. TIME OF DEATH: 3:30 AM |
| 4. SOCIAL SECURITY NUMBER: 217.07.2518 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 14, 1903 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 1013 Omar Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Crownsville | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Crownsville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1013 Omar Drive | | 10f. ZIP CODE: 21032 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 — College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Louis Charles Knopp | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Augusta Kroll | | |
| 19a. INFORMANT'S NAME (Type/Print): Dr. Betty Lou Shubkagel | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1013 Omar Drive, Crownsville, Md. 21032 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: A B Wilson | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Heart Failure | Immed. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Severe Aortic Stenosis | 2½ |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | ASCVD | 4 YRS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 5 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| C. J. Folkemer, MD. | D-14571 | ▶ 4/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Folkemer, 4141 Mt. Rd. Pasadena, Md. 21122

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 11 1989 | Gina Davidson-Randall |

DHMH-18 Rev 1/89

89 13018

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jule Siegel | | | 2. DATE OF DEATH (Month, Day, Year): 4 2 89 | 3. TIME OF DEATH: 0610 M |
| 4. SOCIAL SECURITY NUMBER: 284-01-4892 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/28/98 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): PLEASANT Living Conv. Ctr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Edgewater | | 9c. COUNTY OF DEATH: ANNE ARUNDEL |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ROSE HAVEN | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 625 CALIFORNIA AVE. | | 10f. ZIP CODE: 20714 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: CAUC. |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK | | 16b. KIND OF BUSINESS/INDUSTRY: VENDING CO. |
| 17. FATHER'S NAME (First, Middle, Last): MAURICE EPSTEIN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY LIPSITZ | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. HELEN RESNICK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 625 CALIFORNIA AVE ROSE HAVEN, MD 20714 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MIKRO KODESH BETH ISRAEL | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellsworth Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Squamous Cell Carcinoma, Vulva | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William P. Jones, MD | 29c. LICENSE NUMBER: D06054 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-2-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William P. Jones, MD 695 America Ct. 21035 | | |
| 31. DATE FILED (Month, Day, Year): APR 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

Item#7 Per F.H. FilmG653 7/25/89cg

89 13019

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Claude | S. | Simmons | 5 / 13 / 89 | 12:10 A. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216 36 3798 | 1 [X] M 2 [ ] F | 49 YRS. | | | March 2, ~~1989~~ 1940 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Pasadena | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 986 Duvall Hwy. | 21122 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES (Unknown) | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | | Self Employed Truck Driver | Transportation |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Webster Simmons | Nicie Poole |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Hansel Simmons | 986 Duvall Hwy., Pasadena, MD 21122 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Security Process, Inc. | Catonsville, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Stephen D. Schumann | McCully Funeral Home of Pasadena<br>Pasadena, Maryalnd 21122 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James A. Kaplan, M.D. | OCME | ▶ 5-14-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

James A. Kaplan, M.D. 111 Penn St., Balto., Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 23 1989 | Julia Davidson-Landers |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13020
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GLORIA V. SIMMS | | | | 2. DATE OF DEATH (Month, Day, Year): 4 14 1989 | 3. TIME OF DEATH: 10:25 P M |
| 4. SOCIAL SECURITY NUMBER: 579-50-8971 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3 27 1936 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 1860 Bowman Court | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1860 Bowman Court | | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XXX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO XXX IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO XX Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM BUTLER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HATTIE BUTLER | | | |
| 19a. INFORMANT'S NAME (Type/Print): LILLIAN McGOWAN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): [redacted] Admiral Drive Annapolis, Md. 21401 | | | |
| 20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PINELAWN MEM. PARK | 20c. LOCATION — City or Town, State: Annapolis, Md. 21401 | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Reese, II | 22. NAME AND ADDRESS OF FACILITY: 821 West Street WILLIAM REESE & SONS MORTUARY, P.A. | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. small intestinal cancer | 1½ years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Stuart E. Selonick, MDD | 019838 | ▶ 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stuart E. Selonick, M.D. 51 Franklin St. Annapolis, Md. 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 25 1989 | Julia Davidson-Pinder |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13021
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Franklin SMOUSE
2. DATE OF DEATH (Month, Day, Year): April 3, 1989
3. TIME OF DEATH: 11:30 pM
4. SOCIAL SECURITY NUMBER: 214-05-7270
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 76 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/28/13
8. BIRTHPLACE (State or Foreign Country): Cumberland, MD
9a. FACILITY NAME (If not institution, give street and number): Anne ARundel General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Queen Anne's
10c. CITY, TOWN OR LOCATION: Chester
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: P. O. Box 54
10f. ZIP CODE: 21619
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 8 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auditor - Maryland STate Income Division
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Thomas Ralph Smouse
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Frances Stanton
19a. INFORMANT'S NAME (Type/Print): Dorothy C. Smouse
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 54 Chester, MD 21619
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Stevensville Cemetery
20c. LOCATION — City or Town, State: Stevensville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas K. Helfenbein
22. NAME AND ADDRESS OF FACILITY: Tom Helfenbein Funeral Homes, P.A Rt. 1 Box 66B, Chester, MD 21619

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory srrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in dasth) →
a. Arteriosclerotic cardiomyopathy — 1 year
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus with neuropathy Wolff Parkinson White syndrome and atrial fibrillation Anemia
24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer
29c. LICENSE NUMBER: DO 5928
29d. DATE SIGNED (Month, Day, Year): April 4, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES W. KINZER, MD, ANNAPOLIS, MARYLAND
31. DATE FILED (Month, Day, Year): APR 07 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

a

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-13022

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Calwood S. Somers Jr.

2. DATE OF DEATH: MONTH 5 DAY 2 YEAR 89

3. TIME OF DEATH: 2°° a M

4. SOCIAL SECURITY NUMBER: 218-03-4555

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 79 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8-19-09

8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Gen. Hosp.

9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis

9c. COUNTY OF DEATH: AA

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: PG

10c. CITY, TOWN OR LOCATION: Upper Marlboro

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 11101 Lynford Ct.

10f. ZIP CODE: 20772

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Meat Cutter

16b. KIND OF BUSINESS/INDUSTRY: Grocery

17. FATHER'S NAME (First, Middle, Last): Calwood Smith Somers, Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Molly Duncan

19a. INFORMANT'S NAME (Type/Print): Charlotte A. Somers

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10e

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Southern Mem. Gardens

20c. LOCATION — City or Town, State: Dunkirk, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] RFH

22. NAME AND ADDRESS OF FACILITY: Rausch FH Owings, MD 20736

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Probable acute MI | Immediate |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Congestive Heart Failure | Days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Coronary artery disease | Yrs |
| DUE TO (OR AS A CONSEQUENCE OF): d. | Atherosclerosis | Yrs |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD & pulmonary fibrosis
Atherosclerosis & Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph N. Friend M.D.

29c. LICENSE NUMBER: D17965

29d. DATE SIGNED (Month, Day, Year): ▶ 5/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Friend 205 Ridgely Ave. Annapolis, MD 21401

31. DATE FILED (Month, Day, Year): MAY 8 - 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Anderson

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13023
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Howard Le Roy Stanley | | | | 2. DATE OF DEATH (Month, Day, Year): May 3, 1989 | | 3. TIME OF DEATH: 1:20 PM |
| 4. SOCIAL SECURITY NUMBER: 267.44.1474 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 52 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 24, 1936 | 8. BIRTHPLACE (State or Foreign Country): Nebraska |
| 9a. FACILITY NAME (If not institution, give street and number): 1150 Severnview Drive | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Crownsville | | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Crownsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1150 Severnview Drive | | 10f. ZIP CODE: 21032 | 10g. CITIZEN OF WHAT COUNTRY?: U S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Korean | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Senior Executive | 16b. KIND OF BUSINESS/INDUSTRY: NSA Civil Service |
| 17. FATHER'S NAME (First, Middle, Last): Walter R. Stanley | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Maxine Pittman | |
| 19a. INFORMANT'S NAME (Type/Print): Kathryn D. Stanley | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10A | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baldwin Memorial Cemetery | 20c. LOCATION — City or Town, State: Crownsville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. RESPIRATORY ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MALIGNANT BRAIN TUMOR | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D33757 | ▶ 5-4-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES A SEAGER MD ARNOLD MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 4 - 1989 | [signature] |

DHMH-18 Rev 1/89

ITEM: 23 per ME G-662
4-11-90 cm

89 13024

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Michael | J. | Sturgeon | 5 / 16 / 89 | 11:59 a M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-50-5324 | 1 [X] M 2 [ ] F | 34 YRS. | | | 11/12/54 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| North Arundel Hospital (DOA) | Glen Burnie | Anne Arundel |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 144 Hammerlee Road Apt. L | 21061 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 2yrs. | Carpenter | Construction |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Edwin Sturgeon | Pauline Doulin |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Pauline Sturgeon | 112 10th Avenue Baltimore, Maryland 21225 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill Cemetery | Brooklyn, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Richard E. Davis | Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE AMITRIPTYLINE AND NORTIPTYLINE INTOXICATION
Acute drug overdose
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 5/16/89 | M | 1 [ ] YES 2 [X] NO | Subject ingested drugs |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| HOME | 144 Hammerly Apt. L Anne Arundel Co. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle Jr. Md. | OCME | ▶ 5/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

Item:8 per FH G-658
12-19-89 cm

89 13025

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Irvin Sutton
JAMES I SUTTON

2. DATE OF DEATH (Month, Day, Year): 04-17-89

3. TIME OF DEATH: 5:10 P M

4. SOCIAL SECURITY NUMBER: 238-22-5742

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 10-14-1927

8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA

9a. FACILITY NAME (If not institution, give street and number): KIMBROUGH ARMY COMMUNITY HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: Ft. Meade, MD

9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: ANNE ARUNDEL

10c. CITY, TOWN OR LOCATION: GLEN BURNIE

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 305 GLOSCESTER DRIVE

10f. ZIP CODE: 21061

10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12) / College (1-4 or 5+)

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)

16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Monnie R. Sutton

18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Moore

19a. INFORMANT'S NAME (Type/Print): John Palmer

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1421 Maryland Ave, Severn, MD 21144

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc.

20c. LOCATION — City or Town, State: Catonsville, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]

22. NAME AND ADDRESS OF FACILITY: Cremation Society of MD
Baltimore, MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL INSUFFICIENCY
DIABETES MELLITUS
CORONARY ARTERY & peripheral vascular disease.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: 16958

29d. DATE SIGNED (Month, Day, Year): ▶ 04/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JANET M. JONES, M.D. KIMBROUGH ARMY HOSP, FT. MEADE, MD. 20755

31. DATE FILED (Month, Day, Year): APR 21 1989

32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

Items23a thu 28f Per M.E. FilmG652 6/9/89 CG

89 13026

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| MICHAEL | L. | SMITH | 4 / 15 / 89 | 10:30 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-66-3912 | 1 [X] M 2 [ ] F | 34 YRS. | | | 09-21-54 | Bethesda, MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| #37 Annapolis Terrace Motel | Annapolis | Anne Arundel |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | AA | Annapolis | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| #37 Annapolis Terrace Motel | 21401 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Painter | Construction |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John F. Smith | Thelma M. Waple |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Betty Edmands | 112 Englefield Drive, Gaithersburg, MD 20878 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Westview Crematory | Baltimore, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | Hardesty Funeral Home P.A. 12 Ridgely Avenue, MD Annapolis |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute narcotic and alcohol intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] OOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined | Unknown | M | 1 [ ] YES 2 [X] NO | Unknown |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Unknown | Unknown |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin M.D. | OCME | 4-16-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Julia C. Goodin, M.D. | 111 Penn St., Balto., MD 21201 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 19 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13027 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Albert J. Taylor, Sr. | | | 2. DATE OF DEATH (Month, Day, Year): 5 2 89 | 3. TIME OF DEATH: 0851 M |
| 4. SOCIAL SECURITY NUMBER: 218 28 4742 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 56 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 6/14/33 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Gen Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: AA. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Queen Annes | 10c. CITY, TOWN OR LOCATION: Grasonville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Rt. 1 Box 264 AA Perry Corner | | 10f. ZIP CODE: 21638 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed | 16b. KIND OF BUSINESS/INDUSTRY: Truck Driver | |
| 17. FATHER'S NAME (First, Middle, Last): Charles M. Taylor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Pick | |
| 19a. INFORMANT'S NAME (Type/Print): Frances N. Taylor | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4597 Mountain Rd., Pasaena, Maryland 21122 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veteran Cemetery | 20c. LOCATION — City or Town, State: Crownsville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Plummer | | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William P. Jones MD Deputy | 29c. LICENSE NUMBER: D06054 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): William P. Jones, M.D. 695 America Ct. 21035 | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 - 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

89 13021

1 - STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13028

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Michael Eugene Thomas
2. DATE OF DEATH (Month, Day, Year): 5-2-89
3. TIME OF DEATH: 6:00PM M
4. SOCIAL SECURITY NUMBER: 220-72-8359
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 15 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): Sept. 12, 1973
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Kimborough Army Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Ft. Meade
9c. COUNTY OF DEATH: Anne Arundel Co.

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Severn
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 8549 Pioneer Drive
10f. ZIP CODE: 21144
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Gordon T. Hall
18. MOTHER'S NAME (First, Middle, Maiden Surname): Yvonne Thomas
19a. INFORMANT'S NAME (Type/Print): Yvonne Johnson (Mother)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8549 Pioneer Drive, Severn, MD 21144
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Nat'l Mem. Park
20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden
22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home, 246 N. Washington St., Rockville, MD 20850

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Strangulation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 5-2-89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES [X] NO
28d. DESCRIBE HOW INJURY OCCURED: subject strangled
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Puddle
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Wooded area near C St., Ft. Meade

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr. M.D.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 5-3-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. — 111 Penn Street, Baltimore, MD 21201 vc
31. DATE FILED (Month, Day, Year): MAY 8 - 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13029
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Nell B. Thompson | | | | 2. DATE OF DEATH: MONTH 05 DAY 02 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 502-50-2150 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 95 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 09-03-93 | 8. BIRTHPLACE (State or Foreign Country): Fisher, Minn |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: AA | 10c. CITY, TOWN OR LOCATION: Admiral Heights Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3 Baldridge Road | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 1 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Household |
| 17. FATHER'S NAME (First, Middle, Last): Peter Bowman | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Stack | |
| 19a. INFORMANT'S NAME (Type/Print): J.C.Thompson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Baldridge Road, Annapolis, MD | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Calvary Cemetery | 20c. LOCATION — City or Town, State: Wahpeton, North Dakota |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kimberly S Rowe | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Avenue, Annapolis, MD | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Respiratory Arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Overwhelming Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Aspiration | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hip Fracture 5 status Post Cerebrovascular Accident Parkinson's

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: W Behrens MD | 29c. LICENSE NUMBER: D-36488 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Behrens 2568A Riva Rd, Annapolis, Md. 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 04 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DNMN-18 Rev 1/89

5

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13030 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | | 3. TIME OF DEATH |
| FRANK . TURNER | AKA: WALTER FRANKLIN TURNER, SR. | | 05 | 13 89 | 4.38 AM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
| 242-52-1438 | 1 ☒ M 2 ☐ F | 55 YRS. | | | 11/11/33 | Maryland |
| 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | 9c. COUNTY OF DEATH | |
| NORTH ARUNDEL HOSPITAL | | GLEN BURNIE | | | A.A. COUNTY | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Baltimore | Arbutus | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1251 Locust Avenue | 21227 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | | Foreman | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Walter Turner | Sally Mathews |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Carol C. Turner | 1251 Locust Avenue, Arbutus, MD 21227 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Meadowridge Cemetery | Dorsey, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| | Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory arrest.
DUE TO (OR AS A CONSEQUENCE OF):
b. Severe hypotension,
DUE TO (OR AS A CONSEQUENCE OF):
c. Metastatic carcinoma,
DUE TO (OR AS A CONSEQUENCE OF):
d. Acute renal failure,

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary
Primary peritoneal liver disease.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| U. R. Sundara | D21187 | 5/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 23 (Type or Print) U.R. SUNDARA, M.D. 14 HILLBORN AVE., GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | Julia Davidson-Sundara |

DHMH-18 Rev 1/89

88 13030

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13031

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Jane | Juanita | Turner | 5-12-89 | 6:00AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-96-1085 | 1 ☐ M 2 ☒ F | 24 YRS. | | | 06-15-64 | Washington, D.C. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| North Arundel Hospital | Glen Burnie | Anne Arundel Co. |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Anne Arundel | Denton | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 212a Smith Landing Road | 21629 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | Cashier | Exxon |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Edgerly Sr. | Nina Maddox |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Chester Turner | 212A Smith Landing Road, Denton, MD 21629 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Hillcrest Cemetery | Annapolis, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Bath Funeral Home | 12 Ridgely Avenue Annapolis, MD 21401 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Head and neck injury | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 5-12-89 | 1:24A M | 1 ☐ YES 2 ☒ NO | Driver in auto/rolled over impact |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| road | St. Stephens Church Rd/450 Anne Arundel Co.MD |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 5-12-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 16 1989 | Julia Davidson-Rondell |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

68 13031

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13032
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marjorie A. Tullier
2. DATE OF DEATH (Month, Day, Year): 4 5 89
3. TIME OF DEATH: 4 M
4. SOCIAL SECURITY NUMBER: 436 26 0793
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-13-1924
8. BIRTHPLACE (State or Foreign Country): New Orleans LA
9a. FACILITY NAME (If not institution, give street and number): 39 Murray Ave — RESIDENCE OF DECEDENT
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel
10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 39 Murray Ave
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEMAKER
16b. KIND OF BUSINESS/INDUSTRY: HOME
17. FATHER'S NAME (First, Middle, Last): THOMAS W. SHEPARD SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): EMILIE PITOT
19a. INFORMANT'S NAME (Type/Print): PETER M. TULLIER JR.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 39 MURRAY AVE ANNAPOLIS MD 21401
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD. VET. CEMETERY
20c. LOCATION — City or Town, State: CROWNSVILLE MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles E Ernmyer
22. NAME AND ADDRESS OF FACILITY: TAYLOR FUNERAL CHAPEL 21401 147 GLOUCESTER ST. ANNAPOLIS MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic breast cancer | 15 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stuart E. Jelonick, M.D.
29c. LICENSE NUMBER: 019838 md.
29d. DATE SIGNED (Month, Day, Year): ▶ 4/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 51 Franklin St. Annapolis, Md. 21401
31. DATE FILED (Month, Day, Year)
32. REGISTRAR'S SIGNATURE: APR 06 1989 Julia Davidson-Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13033

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Laura Hunt Townsend
2. DATE OF DEATH (Month, Day, Year): April 14 1989
3. TIME OF DEATH: 4:30 A.M.
4. SOCIAL SECURITY NUMBER: 220-34-7850
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02/26/02
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Ginger Cove
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis, MD
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2308 River Crescent Dr.
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: X
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): -12- College (1-4 or 5+): -0-
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): George Hunt
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lavinia Maratt
19a. INFORMANT'S NAME (Type/Print): Laurie T. Thomas Daughter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1616 Earlham Avenue Crofton, Maryland 21114
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____ — 4-15-89
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory
20c. LOCATION — City or Town, State: Alexandria Fairfax Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Pres. — Robert E Evans
22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie, Maryland 20715

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Arrest. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Carcinoma of Ovary. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Carol Pressey M.D.
29c. LICENSE NUMBER: D 25134
29d. DATE SIGNED (Month, Day, Year): ▶ 4/14/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3 Village Green, Crofton, MD — Carol A. Pressey, M.D.

31. DATE FILED (Month, Day, Year): APR 19 '89
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-16 Rev 1/89

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89 13034

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEROY TAYLOR | | | 2. DATE OF DEATH (Month, Day, Year): 04 17 89 | 3. TIME OF DEATH: 0850 AM M |
| 4. SOCIAL SECURITY NUMBER: 214-40-4812 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-9-1897 | 8. BIRTHPLACE (State or Foreign Country): Baltimore, Md |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | 9c. COUNTY OF DEATH: A.A. COUNTY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Glen Buenie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7503 Woodhaven Ct. | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW I | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12); College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher (Art) | 16b. KIND OF BUSINESS/INDUSTRY: Public School |
| 17. FATHER'S NAME (First, Middle, Last): Le Roy Taylor | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Phyllis Hamm Gwathney | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Phyllis Anderson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7503 Woodhaven Ct. Glen Buenie 21061 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Va. Cem 4-21-89 | 20c. LOCATION — City or Town, State: Balto. Co. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ 2332 W. North Ave. Balto. Md. 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Natural Causes
DUE TO (OR AS A CONSEQUENCE OF):
b. Decreased Awareness
DUE TO (OR AS A CONSEQUENCE OF):
c. Multiple Infarcts
DUE TO (OR AS A CONSEDUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
- Multiple Infarcts
- Hypertension
- Senile Osteoarthritis & Cirrhosis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert B. Kroopnick, M.D. | 29c. LICENSE NUMBER: D14753 | 29d. DATE SIGNED (Month, Day, Year): 4/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): ROBERT B. KROOPNICK, M.D. 95 AQUAHART ROAD, SUITE 203 GLEN BURNIE, MARYLAND 2106

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13035 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Prepared by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joseph M. Todd, JR | | | | | 2. DATE OF DEATH (Month, Day, Year): 04-07-89 | 3. TIME OF DEATH: 0544 M |
| 4. SOCIAL SECURITY NUMBER: 217-16-2098 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 02-05-23 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | | 9c. COUNTY OF DEATH: Anne Arundel |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Arnold | | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 341 BUENA VISTA AVE | | | 10f. ZIP CODE: 21012 | | | 10g. CITIZEN OF WHAT COUNTRY? USA. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: CAUCASIOD |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Typewriter Repair | | | 16b. KIND OF BUSINESS/INDUSTRY: U.S. Govt. | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph M. Todd Sr. | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elise Aiken | | | |
| 19a. INFORMANT'S NAME (Type/Print): VIRGINIA TODD | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS #10 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): [redacted] Glen Haven | | | 20c. LOCATION — City or Town, State: Glen Burnie, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Barranco | | | 22. NAME AND ADDRESS OF FACILITY: BARRANCO SEVERNA PARK, MD 21146 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Adenocarcinoma of the Gastrointestinal tract | One Month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

—

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| S. Killian M.D. | | ▶ 4/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen E. Killian, M.D.; 2525 Riva Rd; Annapolis, Md. 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 13 1989 | Julia Davidson-Kindell |

OHMH-16 Rev 1/89

20+1

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13036
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. It must be signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ELEANOR LOUISE VanDALSUM (Eleanor Louise VanDalsum) | | | 2. DATE OF DEATH (Month / Day / Year) 4 / 13 / 89 | 3. TIME OF DEATH 1106 M |
| 4. SOCIAL SECURITY NUMBER 577-01-2926 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year) 11-28-16 | 8. BIRTHPLACE (State or Foreign Country) VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number) North Arundel Hosp | 9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie | 9c. COUNTY OF DEATH AA | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Md. | 10b. COUNTY AA | 10c. CITY, TOWN OR LOCATION Gambrills, | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 913 Waugh Chapel Rd. | 10f. ZIP CODE 21054 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE CAU, |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) JOHN CARL ROSSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELEANOR C. WINKFIELD |
| 19a. INFORMANT'S NAME (Type/Print) JOSEPH VanDALSUM | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) GENERAL DELIVERY, GREAT MILLS, MARYLAND 20634 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) HUNTT CREMATORY | 20c. LOCATION — City or Town, State WALDORF, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward M. Brinsfield | 22. NAME AND ADDRESS OF FACILITY BRINSFIELD FUNERAL HOME P.O. BOX 279, LEONARDTOWN, MD. 20650 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER William P. Jones MD | 29c. LICENSE NUMBER D06054 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD 695 America Ct. 21035.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) APR 14 '89 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13037
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EMORY EARL VERNON | | | | 2. DATE OF DEATH (Month, Day, Year): 04 05 89 | 3. TIME OF DEATH: 118 AM M |
| 4. SOCIAL SECURITY NUMBER: 218-18-4063 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 06 29 21 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: SEVERN | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 509 PASTURE BROOK ROAD | | 10f. ZIP CODE: 21144 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CORRECTIONAL OFFICER | 16b. KIND OF BUSINESS/INDUSTRY: STATE GOVERNMENT | |
| 17. FATHER'S NAME (First, Middle, Last): FREDERICK P. VERNON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MILDRED W. ROEHNER | |
| 19a. INFORMANT'S NAME (Type/Print): AUDREY M. VERNON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 PASTURE BROOK RD. SEVERN, MARYLAND 21144 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTVIEW MEMORIAL PARK | 20c. LOCATION — City or Town, State: CATONSVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrythmias
DUE TO (OR AS A CONSEQUENCE OF):
b. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
c. N/A
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal failure acute
Infected L knee Replacement

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | N/A | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jorge B Ramirez MD | 29c. LICENSE NUMBER: D09596 | 29d. DATE SIGNED (Month, Day, Year): 4/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type/Print): JORGE B. RAMIREZ, M.D. 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND 21061

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 13038

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRIETTA M. WALSIC
2. DATE OF DEATH (Month, Day, Year): 04 08 89
3. TIME OF DEATH: 0850 AM M
4. SOCIAL SECURITY NUMBER: 212-74-9936
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 99 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-19-1889
8. BIRTHPLACE (State or Foreign Country): Poland

9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: /
10c. CITY, TOWN OR LOCATION: Baltimore County
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1531 Ridgely St.
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: at home

17. FATHER'S NAME (First, Middle, Last): unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown

19a. INFORMANT'S NAME (Type/Print): John G. Walsic
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 Vernon Ave. Glen Burnie Md. 21061

20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cem.
20c. LOCATION — City or Town, State: Balto., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J. Brown & Son, Inc. Funeral Home
22. NAME AND ADDRESS OF FACILITY: John J. Brown & Son, Inc. 901 Hollins St. 21223

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF): — 30 days

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Atherosclerosis — DUE TO (OR AS A CONSEQUENCE OF):

c. Hypertension — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Left hip intertrochanteric fracture (25-Feb-89)

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard E. Fisher M.D.
29c. LICENSE NUMBER: DO 2519
29d. DATE SIGNED (Month, Day, Year): ▶ April 8-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): RICHARD FISHER, M.D. 4710 PENNINGTON AVENUE BALTIMORE, MARYLAND 21226

31. DATE FILED (Month, Day, Year): APR 11 1989
32. REGISTRAR'S SIGNATURE: Gordon Andrews

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13039 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Henry Peter Walsky / HENRY P. WALSKY | | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 9 89 | 3. TIME OF DEATH: 935 P M |
| 4. SOCIAL SECURITY NUMBER: 103-14-0469 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Sept. 16, 1910 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): AA Gen. Hosp / Anne Arundel General Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 512 Evergreen Road | | 10f. ZIP CODE: 21146 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO; IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Charles Joseph Walsky | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Michaline Banaszek |
| 19a. INFORMANT'S NAME (Type/Print): Susan W. Gray | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 522 Pinetree Drive, Severna Park, MD 21146 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc | 20c. LOCATION — City or Town, State: Catonsville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. M. Loewner | 22. NAME AND ADDRESS OF FACILITY: Cremation Society of MD, Baltimore, Maryland 21228 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple myeloma | 5 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Parkinson's Disease; Chronic Dementia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Evan W Cole MD | 29c. LICENSE NUMBER: D16354 Md. | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E.W. COLE III MD 51 FRANKLIN ST ANNAPOLIS Md 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Githa Davidson-Randall |

DHMH-16 Rev 1/89

88 13036

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13040
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Henry Warfel Sr. | | | | 2. DATE OF DEATH (Month, Day, Year): April 2 1989 | 3. TIME OF DEATH: 1:07 A M |
| 4. SOCIAL SECURITY NUMBER: 212.40.3557 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 47 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Feb. 2, 1942 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 360 Gatewater Court, #102 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Hanover | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7646 Watts Avenue | | 10f. ZIP CODE: 21076 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter- Self employed | 16b. KIND OF BUSINESS/INDUSTRY: Carpentry | |
| 17. FATHER'S NAME (First, Middle, Last): Charles G. Warfel, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hilda R. Schultz | |
| 19a. INFORMANT'S NAME (Type/Print): Charles G. Warfel, Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7646 Watts Ave., Hanover, Md. 21076 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Hopkins | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Shotgun Wound to Face | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) house | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-2-89 | 28b. TIME OF INJURY: 1:00A M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: subject was shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): house | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 360 Gatewater Ct., #102, Glen Burnie, Md. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell, M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-2-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Balto., Md. 21201 | | |
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 13041

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RUTH L. WATERMAN | | 2. DATE OF DEATH: MONTH 5 DAY 11 YEAR 89 | 3. TIME OF DEATH: 7:45 P.M. |
| 4. SOCIAL SECURITY NUMBER: 096-16-2843 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-29-02 |
| 8. BIRTHPLACE (State or Foreign Country): New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | 9c. COUNTY OF DEATH: AACo | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 121 Lake View Drive | 10f. ZIP CODE: 21403 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Lewis Dayton | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Alice Young | | |
| 19a. INFORMANT'S NAME (Type/Print): Roger S. Waterman | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 121 Lake View Drive, Annapolis, MD 21403 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan | 20c. LOCATION — City or Town, State: Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey S. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CONGESTIVE HEART FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Seager | 29c. LICENSE NUMBER: D33757 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES A. SEAGER M.D. 269 PENINSULA FARM ROAD, ARNOLD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 16 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| (CHARLES) CHARLIE | WHITFIELD | JR. | 05 26 89 | 1125 PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 239-01-8199 | 1 [X] M 2 [ ] F | 72 YRS. | | | 7/31/16 | NC |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 717 N. PAYSON STREET | 21217 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | PRESSOR | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| CHARLIE WHITFIELD | ROSA ALBRITTON |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CAROL WHITFIELD BRAXTON | 7904 TYLER STREET/LANHAM, MD 20706 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | SUNSET CEMETERY | FARMVILLE, NC |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | WM. C. MARCH F/H 1101 E. NORTH AVENUE |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio. pulmonary arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): CHF | |
| | b. DUE TO (OR AS A CONSEQUENCE OF): ASCVD | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(1) ASCVD (3) Malnutrition
(2) Septicemia (4) S/P. BKA

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D. | D-19528 | ▶ 5/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) ELIO M. GRECO, M.D. 1900 W. PATAPSCO ROAD BALTIMORE, MARYLAND 21229

31. DATE FILED (Month, Day, Year) MAY 31 1989 SIGNATURE [signature]

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Carrie E. Walker | | | 2. DATE OF DEATH (Month, Day, Year): 4-20-89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 216-16-4039 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-7-21 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: AA Co |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 11 Parole Street | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES: XXXX | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: XXXX | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | 16b. KIND OF BUSINESS/INDUSTRY: U.S. NAVAL ACADEMY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): DAVID CARR | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA CARR |
| 19a. INFORMANT'S NAME (Type/Print): WILLIAM JOHNSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 927 Oxford Avenue Aberdeen, Md. 21001 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HIKL CREST CEMETERY | 20c. LOCATION — City or Town, State: Annapolis, Md. 21401 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Reese, II | 22. NAME AND ADDRESS OF FACILITY: 821 West Street Annapolis, Md21401 WILLIAM REESE & SONS MORTUARY, P.A. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. metastatic carcinoma of the lung | 1 y |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Adrenal metastasis, chronic obstructive pulm disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 9 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gregory A. Duffield MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE | |

DHMH-16 Rev 1/89

89 13044

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ___ should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ESTELLE L WRIGHT | | | | | 2. DATE OF DEATH (Month, Day, Year): 04 28 89 | 3. TIME OF DEATH: 536 PM M |
| 4. SOCIAL SECURITY NUMBER: 219-30-9593 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/ 04/ 1903 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 165 MOUNTAIN ROAD | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: HOME |
| 17. FATHER'S NAME (First, Middle, Last): BENJAMIN STEPHNEY | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): MR. MILTON WRIGHT | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 165 MOUNTAIN ROAD, PASADENA, MARYLAND 21122 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK | 20c. LOCATION — City or Town, State: BALTIMORE, CO., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Rollins | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Coronary occlusion | few hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Congestive heart failure | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabetes mellitus | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul J. Chang M.D. | 29c. LICENSE NUMBER: D04096 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL J. CHANG, M.D. 801 CRAIN HWY. SE GLEN BURNIE, MD 21061 | | |
| 31. DATE FILED (Month, Day, Year): MAY 4 _ 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13045 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial transit permit.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET ANN WRIGHT | | 2. DATE OF DEATH (Month, Day, Year): April 25 1989 | 3. TIME OF DEATH: 1125 PM M |
| 4. SOCIAL SECURITY NUMBER: 216.12.1171 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 17, 1923 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | 9c. COUNTY OF DEATH: A.A. COUNTY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 531 Manor Road | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last): Lewis T. Marshall | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Walston | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Wayne A. Wright | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 611 Wardour Road, Glen Burnie, Md. 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc. | 20c. LOCATION — City or Town, State: Catonsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harold B Pinson | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | 2 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Superior vena cava syndrome | 16 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Advanced Lung Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D20431 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-26-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print): LONG S. HSU, M.D. 500 HOSPITAL DRIVE, SUITE 230 GLEN BURNIE, MARYLAND 21061 | | |
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13046 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Martha Marie Waldman | | | | | 2. DATE OF DEATH: MONTH May DAY 2 YEAR 1989 | 3. TIME OF DEATH: 12:01A M |
| 4. SOCIAL SECURITY NUMBER: 215.12.5935 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov. 4, 1922 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 108 South Third Avenue (Ferndale) | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 108 South Third Avenue (Ferndale) | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine OPerator | 16b. KIND OF BUSINESS/INDUSTRY: Western Electric |
| 17. FATHER'S NAME (First, Middle, Last): Alexander J. Novakowski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Marie Wienesski | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Alfred J. Novakowski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 South Third Ave.(Ferndale)Glen Burnie, Md. 21061 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc. | 20c. LOCATION — City or Town, State: Catonsville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard B Pierson | | 22. NAME AND ADDRESS OF FACILITY: #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocarchal Infarction DUE TO (OR AS A CONSEQUENCE OF): | Hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Extensive Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): | Years |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Hilary O'Herlihy MD | 29c. LICENSE NUMBER: D-15860 | 29d. DATE SIGNED (Month, Day, Year): May 2nd 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Hilary O'Herlihy 325 Hospital Drive, Glen Burnie, Maryland 21061

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 4 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13047

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH | DAY | YEAR | 3. TIME OF DEATH |
| GOLDEN | EDWARD | WARD | JR | 04 | 10 | 89 | 3.45 PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|---|---|
| 229-03-4734 | 1 [X] M 2 [ ] F | 70 YRS. | | | | | 3-17-1919 | Virginia |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Ann Arundel | Glen Burnie | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1402 Houghton Rd. | 21061 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 8+) | | |
| 11 yrs. | | Supervisor | Navel Ship Research Development Center |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Golden E. Ward | Lola Ashby |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Doris Ames Ward | 1402 Houghton Rd. Glen Burnie, Md. 21061 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Belle Haven Cemetery | Belle Haven, Virginia |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ R.C. Doughty Jr. | Doughty Funeral Home, Inc. P.O. Box 633 Exmore, Va. 23350 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Ventricular Fibrillation | 30-60 min |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Extensive Coronary Artery Disease | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

a) Congestive Heart Failure b) Pulmonary Edema c) Diabetes Mellitus d) Chronic Renal Failure

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Stan Marsky MD | | ▶ 4-10-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) ALBERT T. GREGETH 325 HOSPITAL DRIVE, SUITE 208 GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| APR 21 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

Dr. Lichtenstein

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13048 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elizabeth P. ~~Hahn~~ Warren | | | 2. DATE OF DEATH: Month 04 Day 16 Year 89 | 3. TIME OF DEATH: 1045 M |
| 4. SOCIAL SECURITY NUMBER: 209-46-0988 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Apr. 15, 1897 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): A.A.General Hospital & Med.Cntr. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 24 Truckhouse Road | | 10f. ZIP CODE: 21146 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Ferdinand Peck | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Ann Stanhope | |
| 19a. INFORMANT'S NAME (Type/Print): Barbara Elliott | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1363 Moyer Road, Annapolis, MD 21403 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Manasota Memorial Cem. | 20c. LOCATION — City or Town, State: Brsdenton, Florida |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert L. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Advanced Age

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jack Lichtenstein, M.D. | 29c. LICENSE NUMBER: D08194 | 29d. DATE SIGNED (Month, Day, Year): 4/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 17 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Hendrix |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2

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DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13049
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM A. WILLIAMS | | | 2. DATE OF DEATH (Month, Day, Year): APRIL 9 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 202-16-0569 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): AUG. 8 1922 | 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL GENERAL HOSP. | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: ANNE ARUNDEL |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ~~22 WILELINOR DRIVE~~ ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 22 WILELINOR DRIVE | | 10f. ZIP CODE: 21037 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII KOREA | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Physician | 16b. KIND OF BUSINESS/INDUSTRY: PATHOLOGY |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | |
| 19a. INFORMANT'S NAME (Type/Print): DAWN L. WILLIAMS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 WILELINOR DR. EDGEWATER, MD. 21037 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. MARY'S CEMETERY | 20c. LOCATION — City or Town, State: ANNAPOLIS, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert L. Taylor | | 22. NAME AND ADDRESS OF FACILITY: TAYLOR FUNERAL CHAPEL ANNAPOLIS, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO |

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: GA Mitchell MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 4/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGORY A. MITCHELL 207 RIDGLEY AVE. ANNAPOLIS, MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): APR 11 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

10x1

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13050 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 2, 3 should be retained for use as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Louise M. Woodfield | | 2. DATE OF DEATH (Month, Day, Year): 04-08-89 | 3. TIME OF DEATH: 8 A M |
| 4. SOCIAL SECURITY NUMBER: 218-36-6379 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11/06/00 |
| 8. BIRTHPLACE (State or Foreign Country): Cumberston, MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 4733 Woodfield Lane (Home) | 9b. CITY, TOWN OR LOCATION OF DEATH: Galesville | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: AA | 10c. CITY, TOWN OR LOCATION: Galesville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4733 Woodfield Lane | 10f. ZIP CODE: 20765 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Household | |
| 17. FATHER'S NAME (First, Middle, Last): John Edward Hopkins | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie May Hunt | | |
| 19a. INFORMANT'S NAME (Type/Print): Jessie M. Gott | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4722 Woodfield Road, Galesville, MD | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodfield C emetery | 20c. LOCATION — City or Town, State: Galesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bat. J. Hardesty Jr | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home Galesville, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cerebral infarction | Days. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cerebrovascular disease | Months. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary tract infection
Pulmonary tumor

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gerard Blanco MD | 29c. LICENSE NUMBER: MD 18615 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4/9/89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GERARD BLANCO MD. 8 SEVERN GLEN ROAD SEVERNA PARK MD 21146 | | |
| 31. DATE FILED (Month, Day, Year): APR 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

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88 13020

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13051
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. ... permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): STEPHEN IRA WOODS | | | 2. DATE OF DEATH (Month, Day, Year): April 9, 1989 | 3. TIME OF DEATH: 6:21 P. M |
| 4. SOCIAL SECURITY NUMBER: 217-30-4897 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 25, 1934 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: P.G. | 10c. CITY, TOWN OR LOCATION: Laurel | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 255 Brock Bridge Road | 10f. ZIP CODE: 20707 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean Conflict | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: XX | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Insurance Salesman | 16b. KIND OF BUSINESS/INDUSTRY: Mutual of Omaha |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Charles Woods | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Tishman |
| 19a. INFORMANT'S NAME (Type/Print): Margot Woods (Wife) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 255 Brock Bridge Road; Laurel, Md. 20707 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King David Memorial Garden | 20c. LOCATION — City or Town, State: Falls Church, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sarah L. Stone | 22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIAC ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PRESUMED MYOCARDIAL INFARCTION | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D24942 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-10-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GREGORY A COMPTON 8317 CHERRY LN LAUREL MD 20707 | | |
| 31. DATE FILED (Month, Day, Year): APR 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-18 Rev 1/89

25+1

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13052 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE Washington WYATT | | | 2. DATE OF DEATH: MONTH May DAY 01 YEAR 1989 | 3. TIME OF DEATH: 0855 AM M |
| 4. SOCIAL SECURITY NUMBER: 216.16.8154 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 22, 1916 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severn | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7909 Clark Station Road | | 10f. ZIP CODE: 21144 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 6 +): NA | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator | 16b. KIND OF BUSINESS/INDUSTRY: Vectra Corp. | |
| 17. FATHER'S NAME (First, Middle, Last): Mack Wyatt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Perry | |
| 19a. INFORMANT'S NAME (Type/Print): Myrtle M. Wyatt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Singleton Funeral Home 1 Second Avenue S.W. Glen Burnie, Maryland 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular Fibrillation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Advanced Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print): GLENN F. ROBBINS, M.D. 1404 CRAIN HIGHWAY, SUITE 300 GLEN BURNIE, MARYLAND 21061

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13053 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 [illegible] by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Laura Engberg Young | | | 2. DATE OF DEATH Month 04/12/89 Day Year | 3. TIME OF DEATH 4 00 AM |
| 4. SOCIAL SECURITY NUMBER: 485-32-1478 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 89 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 06/27/99 | 8. BIRTHPLACE (State or Foreign Country): Iowa |
| 9a. FACILITY NAME (If not institution, give street and number): 178 Topeg Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Severna Park | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 178 Topeg Drive | | 10f. ZIP CODE: 21146 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasion |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1-4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Education |
| 17. FATHER'S NAME (First, Middle, Last): — | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): — | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Helen Peters | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 178 Topeg Drive Severna Park MD 21146 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hills of Rest Cemetery | 20c. LOCATION — City or Town, State: Sioux Falls, S>D>South Da |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James E. Barranco | | 22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic colon cancer | 9 mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph N. Friend M.D | 29c. LICENSE NUMBER: D17965 | 29d. DATE SIGNED (Month, Day, Year) ▶ 4/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph N. Friend 205 Ridgely Ave Annapolis, Md.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rendell |

12

OHMH-16 Rev 1/89

89 13054

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Joseph H Hopping
2. DATE OF DEATH (Month, Day, Year): 3 - 6 - 89
3. TIME OF DEATH: 5:32 a M
4. SOCIAL SECURITY NUMBER: 579-38-4523
5. SEX: 1 M 2 F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-27-08
8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS
9c. COUNTY OF DEATH: AA Co

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: MONTGOMERY
10c. CITY, TOWN OR LOCATION: SILVER SPRING
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1001 SPRING STREET #528
10f. ZIP CODE: 20910
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [✓] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [✓] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [✓] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRINTING OFFICE
16b. KIND OF BUSINESS/INDUSTRY: US GOVERNMENT
17. FATHER'S NAME (First, Middle, Last): SILAS VAN HOPPING
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY E. (UNKNOWN)
19a. INFORMANT'S NAME (Type/Print): LORETTA Y. HOPPING WIFE
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 SPRING STREET #528 SILVER SPRING, MD 20910
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY
20c. LOCATION — City or Town, State: BRENTWOOD, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Factor
22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, 500 UNIV BLVD WEST SILVER SPRING, MD 20901

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary Arrest. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| b. | End Stage Respiratory Failure (COPD) | 2 yr. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | R.L.L. Pneumonia | 3 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | Septicemia | 3 days. |

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
29c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
29d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ronald C. Sroka, M.D.
29c. LICENSE NUMBER: D18480
29d. DATE SIGNED (Month, Day, Year): ▶ 3/6/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RONALD C SROKA, MD 3 ILLINOIS CIRCLE CROFTON MD 21114
31. DATE FILED (Month, Day, Year): MAR 7'89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13055
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jacque George AYD | | | | 2. DATE OF DEATH (Month, Day, Year): May 13, 1989 | 3. TIME OF DEATH: 2:35 PM |
| 4. SOCIAL SECURITY NUMBER: 216-09-9497 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6-24-1914 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5421 Pembroke Ave. | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. / College (1-4 or 5+): 4 Yrs. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Director-Food Control | 16b. KIND OF BUSINESS/INDUSTRY: Baltimore City | |
| 17. FATHER'S NAME (First, Middle, Last): Ignatius Ayd | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Offley | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Isabelle Ayd | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5421 Pembroke Ave.,Balto., Md. 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer Cem. 5-17-89 | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roy H. Cather Roy H. Cather | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck,Inc.,5305 Harford Rd.,Balto.,Md. 21214 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of the Lung with Metastasis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Heart Failure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Celiar E. Parra M.D. | 29c. LICENSE NUMBER: 00430 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Celiar Parra MD 9000 Franklin Square Dr. Balto.Md. 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudrow |

DHMH-16 Rev 1/89

88 13022

Item #4 film #g152 per: F.H. 8-16-89 JA

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13056 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MORRIS ARONOVITCH | | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 18 / 1989 | 3. TIME OF DEATH: 6:40 AM |
| 4. SOCIAL SECURITY NUMBER: 215-03-7950 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-19-14 | 8. BIRTHPLACE (State or Foreign Country): M.D. |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN, MD | | 9c. COUNTY OF DEATH: BALTIMORE |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3 TROTTERS COURT APT T4 | | 10f. ZIP CODE: 21208 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] ND IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COMPTROLLER | 16b. KIND OF BUSINESS/INDUSTRY: AUTO AGENCY | | | |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL ARONOVITCH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH FAGAN | | | |
| 19a. INFORMANT'S NAME (Type/Print): BEATRICE ARONOVITCH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 TROTTERS CT., APT. T-4 BALTO., MD 21208 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY | | 20c. LOCATION — City or Town, State: REISTERSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Levin | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE PULMONARY EDEMA

DUE TO (OR AS A CONSEQUENCE OF):
b. DILATED CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. OLD MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):
d. ISCHEMIC CORONARY ARTERY DISEASE

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Failure
Crohn's Disease (Inactive)

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| B Kutsche MD | D-35788 | 5/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B. KUTSCHE MD 5401 OLD COURT ROAD RANDALLSTOWN, MD 21133 BALT COUNTY GEN HOSPITAL

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 24 1989 | Julia Davidson-Rudnick |

DHMH-16 Rev 1/89

88 13026

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13057
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LAURENCE R. BAGWELL | | | 2. DATE OF DEATH: MONTH May DAY 22, YEAR 1989 | 3. TIME OF DEATH: 2:15 p M |
| 4. SOCIAL SECURITY NUMBER: 213-03-1361 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov.26,1919 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 8743 Old Harford Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Parkville | | 9c. COUNTY OF DEATH: Baltimore Co. |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Parkville | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8743 Old Harford Road | | 10f. ZIP CODE: 21234 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 Years; College (1-4 or 5 +): ---------- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tool & Die Maker | | 16b. KIND OF BUSINESS/INDUSTRY: Maintenance |
| 17. FATHER'S NAME (First, Middle, Last): John Wilbur Bagwell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara O. Fick | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret M. Bagwell | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8743 Old Harford Rd. Baltimore, Maryland 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park | | 20c. LOCATION — City or Town, State: Balto.Co.,Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson | | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cancer esophagus | 1 yr. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Mal-nutrition. Depression

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | | 29c. LICENSE NUMBER: D-17992 | 29d. DATE SIGNED (Month, Day, Year): 5/23/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1006 Taylor Avenue Balto md 21204. | | | |
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dawson-Reaves | | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13058

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

2

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES CHESTER BOWMAN
2. DATE OF DEATH — MONTH: 5 DAY: 29 YEAR: 89
3. TIME OF DEATH: 23:21 M
4. SOCIAL SECURITY NUMBER: 218-44-1031
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 42 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-19-46
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Rossville
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Essex
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1661 Poles Rd.
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber
16b. KIND OF BUSINESS/INDUSTRY: Local #48
17. FATHER'S NAME (First, Middle, Last): Charles C. Bowman, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Quesinberry
19a. INFORMANT'S NAME (Type/Print): Mrs. Carole L Bowman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1661 Poles Rd. Baltimore, Maryland 21221
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Zion Church Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leasdale Funeral Home
22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROBABLE CEREBRAL ANEURYSM

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. HISTORY OF CEREBRAL ANEURYSM SURGERY

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J.M.N. ASSISTANT DEPUTY MEDICAL EXAMINER
29c. LICENSE NUMBER: 027197
29d. DATE SIGNED (Month, Day, Year): ▶ 5/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.M. NIEHOFF, MD 9000 FRANKLIN SQUARE DR. BALTO, MD. 21237

31. DATE FILED (Month, Day, Year): MAY 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

8

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13059
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ETHEL M. BURNS | | | 2. DATE OF DEATH: MONTH 5 DAY 23 YEAR 89 | 3. TIME OF DEATH: 5:08AM M |
| 4. SOCIAL SECURITY NUMBER: 214-03-2615 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2/5/09 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GBMC | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: BALTIMORE Co. | 10c. CITY, TOWN OR LOCATION: TOWSON | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 800 SOUTHERLY Road #803 | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas J. Jennings | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Quinn | |
| 19a. INFORMANT'S NAME (Type/Print): R. Thomas Burns | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 Southerly Rd. #803 Towson, Maryland 21204 | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CEREBRAL HYPOXIA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CARDIORESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D 15561 | 29d. DATE SIGNED (Month, Day, Year): 5/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Biddison, M.D. G.B.M.C.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Biddison-Rudasill |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13060 REG. NO.

1271

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Raymond John Bonczewski | | | 2. DATE OF DEATH Month: 05 Day: 22 Year: 89 | 3. TIME OF DEATH: 6:20 P. M |
| 4. SOCIAL SECURITY NUMBER: 201-26-7843 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 54 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10-01-34 | 8. BIRTHPLACE (State or Foreign Country): Pa. |
| 9a. FACILITY NAME (If not institution, give street and number): 7812 Eastdale Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Colgate | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Colgate | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7812 Eastdale Road | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Korea | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Millwright | 16b. KIND OF BUSINESS/INDUSTRY: Beth. Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Michael Bonczewski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Racaczewski | | |
| 19a. INFORMANT'S NAME (Type/Print): Rosemary M. Bonczewski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7812 Eastdale Rd. Baltimore, Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cem. | | 20c. LOCATION — City or Town, State: Baltimore City, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Zeiler | | 22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARCINOMA of Colon with
DUE TO (OR AS A CONSEQUENCE OF): Metastases

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D 35410 | ▶ 5.23.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 24 1989 | [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13061

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Everett Stanley Burnham | | | 2. DATE OF DEATH (Month, Day, Year): May 19, 1989 | 3. TIME OF DEATH: 1145 A M |
| 4. SOCIAL SECURITY NUMBER: 212-01-8860 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 9, 1905 | 6. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Frederick Villa Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 711 Academy Road | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dept. Manager | 16b. KIND OF BUSINESS/INDUSTRY: McCormick | |
| 17. FATHER'S NAME (First, Middle, Last): Walter E. Burnham | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jane Gillian | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Cecelia Burnham | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): C/O 6501 Dolphin Court Glen Burnie, MD 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olive Cemetery | 20c. LOCATION — City or Town, State: Randallstown, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Bronchogenic Carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multifocal atrial tachycardia
Gastro intestinal Bleeding

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD Attending Physician | 29c. LICENSE NUMBER: D30631 | 29d. DATE SIGNED (Month, Day, Year): 5/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A Alan Reisinger MD 5911 Old Frederick Rd Balto Md 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasa |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13062
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles Howard Bishop | | | 2. DATE OF DEATH: Month 5, Day 21, Year 1989 | 3. TIME OF DEATH: 950 A M. |
| 4. SOCIAL SECURITY NUMBER: 212-05-2405 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/23/17 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): 4628 Magnolia Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Halethorpe, Maryland | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Halethorpe | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4628 Magnolia Avenue | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: W W 2 | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bartender | 16b. KIND OF BUSINESS/INDUSTRY: Liquor | |
| 17. FATNER'S NAME (First, Middle, Last): John W. Bishop | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Bertha Hammond | |
| 19a. INFORMANT'S NAME (Type/Print): Leon L. Lineburg | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5309 East Drive Arbutus, Maryland 21227 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cemetery | 20c. LOCATION — City or Town, State: Dorsey, Howard Co. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Balto., Md. 21227 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive heart failure | 7 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic CVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Herbert J. Levickas M.D. | 29c. LICENSE NUMBER: D15958 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/24/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Herbert J. Levickas, MD 5404 East Drive Baltimore, Md 21227 | | |
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 May 22, 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13063
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Lloyd John Brewer

**2. DATE OF DEATH** (Month, Day, Year): 05 23 89

**3. TIME OF DEATH**: 12:55 a M

**4. SOCIAL SECURITY NUMBER**: 217-09-4123

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 78 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): May 12 1911

**8. BIRTHPLACE** (State or Foreign Country): North Carolina

**9a. FACILITY NAME** (If not institution, give street and number): Greater Baltimore Medical Center

**9b. CITY, TOWN OR LOCATION OF DEATH**: Towson

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Timonium

**10d. INSIDE CITY LIMITS?**: 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 2203 Eastridge Road

**10f. ZIP CODE**: 21093

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 1932 - 1935

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Sales Representative

**16b. KIND OF BUSINESS/INDUSTRY**: Shoe Sales

**17. FATHER'S NAME** (First, Middle, Last): John Emmanuel Brewer

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Clara Nancy Knouse

**19a. INFORMANT'S NAME** (Type/Print): Betty J. Brewer

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2203 Eastridge Rd., Timonium, Md. 21093

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gardens

**20c. LOCATION — City or Town, State**: Timonium, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Martin D. Lawson

**22. NAME AND ADDRESS OF FACILITY**: Lemmon-Mitchell-Wiedefeld
10 W. Padonia Rd., Timonium, Md.21093

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Multiorgans Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Irreversible Hypovolemic Shock
DUE TO (OR AS A CONSEQUENCE OF):
c. Ruptured Abdominal Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?**: 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?**: 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?**: 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?**: 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Bassam Rizk

**29c. LICENSE NUMBER**

**29d. DATE SIGNED** (Month, Day, Year): 5/23/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Bassam Rizk, M.D. G.B.M.C.

**31. DATE FILED** (Month, Day, Year): MAY 26 1989

**32. REGISTRAR'S SIGNATURE**: Julia Deadson-Sanders

12

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13064 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Dorothy E. BOWERS

**2. DATE OF DEATH** (Month, Day, Year): May 17, 1989

**3. TIME OF DEATH**: 6:00 P M

**4. SOCIAL SECURITY NUMBER**: 213529203

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 93 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): APRIL 14, 1896

**8. BIRTHPLACE** (State or Foreign Country): DELAWARE

**9a. FACILITY NAME** (If not institution, give street and number): FRANKLIN SQUARE

**9b. CITY, TOWN OR LOCATION OF DEATH**: ROSEDALE

**9c. COUNTY OF DEATH**: Baltimore, County

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**: CARROLL

**10c. CITY, TOWN OR LOCATION**: FINKSBURG

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 2728 Leppo Lane

**10f. ZIP CODE**: 21048

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 8+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): AT Home

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Unknown Cole MARY

**16. MOTHER'S NAME** (First, Middle, Maiden Surname): Unknown

**19a. INFORMANT'S NAME** (Type/Print): FAMILY RECORDS

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): GARDENS OF FAITH

**20c. LOCATION — City or Town, State**: ROSEDALE, MD.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Ralph T. Evans Jr.

**22. NAME AND ADDRESS OF FACILITY**: EVANS CHAPEL OF MEMORIES 8300 HARFORD ROAD - PARKVILLE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Bradley Z. Spitz

**29c. LICENSE NUMBER**: N/A

**29d. DATE SIGNED** (Month, Day, Year): 5/17/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Bradley Spitz, M.D. 9000 Franklin Square Dr. Baltimore 21237

**31. DATE FILED** (Month, Day, Year): MAY 26 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Landers

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13065

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

22

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Marjorie Case Brannan | | | | 2. DATE OF DEATH (Month, Day, Year) 05-17-89 | 3. TIME OF DEATH 325 AM |
| 4. SOCIAL SECURITY NUMBER 216-46-0179 | 5. SEX 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday) 92 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 09-09-96 | 8. BIRTHPLACE (State or Foreign Country) Indiana |
| 9a. FACILITY NAME (If not institution, give street and number) Broadmeade | | 9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville | | 9c. COUNTY OF DEATH Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MD | 10b. COUNTY Baltimore | 10c. CITY, TOWN OR LOCATION Cockeysville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER 13801 York Rd. | | 10f. ZIP CODE 21030 | 10g. CITIZEN OF WHAT COUNTRY? US |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| Elementary/Secondary (0-12): 12 yr | College (1-4 or 5+): 4 yr | Housewife | Homemaker |
| 17. FATHER'S NAME (First, Middle, Last) Myron S. Case | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Boyd | |
| 19a. INFORMANT'S NAME (Type/Print) Robert R. Brannan, | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 South Wind Road, Towson, Md. 21204 | |
| 20a. METHOD OF DISPOSITION ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery | 20c. LOCATION — City or Town, State Pikesville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Bryan W. Clary | | 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DIABETES MELLITUS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Walter N. Hepner M.D. | D23450 | ▶ 5/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Walter N. Hepner, M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 19 1989 | Julia Davidson-Rudasill |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13066 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNE FROSLEV BARNETT | | | 2. DATE OF DEATH (Month, Day, Year): MAY 1, 1989 | 3. TIME OF DEATH: 12 35 M |
| 4. SOCIAL SECURITY NUMBER: 218-22-0165 | 5. SEX: 1 ☐ M 2 XX F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 4, 1898 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): Presbyterian Home of Maryland | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson, | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 400 Georgia Court | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 YeaRS; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last): Andrew P. Frosleu | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Petersen | |
| 19a. INFORMANT'S NAME (Type/Print): Presbyterian Home of Maryland | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 400 Georgia Court, Towson, MAryland 21204 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodbine Cemetery | 20c. LOCATION — City or Town, State: Oceanport, New Jersey |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Bennicke, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO Respiratory Arrest | MIN |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOsclerotic CARDIOVascular D | YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOARTHritis -

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Retirement home

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. | 29c. LICENSE NUMBER: D11026 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sidney J. Venable, Jr., M.D. 7215 York Rd. Baltimore, Maryland 21212

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rhodes |

DHMH-16 Rev 1/89

89 13067

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) C. William Brandt | | | 2. DATE OF DEATH (Month, Day, Year) May 13, 1989 | 3. TIME OF DEATH 5:35 p M |
| 4. SOCIAL SECURITY NUMBER 215-01-1778 | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 79 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4-29-1910 | 8. BIRTHPLACE (State or Foreign Country) Balto. Md. |
| 9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | 9c. COUNTY OF DEATH Baltimore County |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE Md. | 10b. COUNTY Baltimore | 10c. CITY, TOWN OR LOCATION Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER 15 Walnut Avenue | | 10f. ZIP CODE 21206 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 5th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dental Tech. | 16b. KIND OF BUSINESS/INDUSTRY Hite Dental Lab | |
| 17. FATHER'S NAME (First, Middle, Last) William Henry Brandt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Alt | |
| 19a. INFORMANT'S NAME (Type/Print) William H.A. Brandt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11B Spindrift Circle Baltimore, Md.-21234 | | |
| 20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | 20c. LOCATION — City or Town, State Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Kathleen M. Murphy | 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. | 6415 Belair Road Baltimore, Md.-21206 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypoxemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Esophageal Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Laura Meritt MD | 29c. LICENSE NUMBER N/A | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/13/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Laura Meritt MD 9000 Franklin Square Dr. Balto, Md. 21237 | | | |
| 31. DATE FILED (Month, Day, Year) MAY 15 1989 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randazzo | | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13068

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): WARREN E. BITTRICK

**2. DATE OF DEATH** — MONTH: May DAY: 9, YEAR: 1989

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 212 05 4710

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): May 16, 1914

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): 914 Fairway Drive

**9b. CITY, TOWN OR LOCATION OF DEATH**: Towson, Md.

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Towson

**10d. INSIDE CITY LIMITS?**: 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 914 Fairway Drive

**10f. ZIP CODE**: 21204

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**: Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4+

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Engineer

**16b. KIND OF BUSINESS/INDUSTRY**: Gas & Electric Co.

**17. FATHER'S NAME** (First, Middle, Last): Edward Bittrick

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Caroline Kroell

**19a. INFORMANT'S NAME** (Type/Print): Mrs. Emilie B. Bittrick

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 914 Fairway Drive Towson, Md. 21204

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gardens

**20c. LOCATION — City or Town, State**: Timonium, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ C. Sherman Bowers Jr.

**22. NAME AND ADDRESS OF FACILITY**: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.** — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. CARDIAC ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CHRONIC RENAL FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

c. (END STAGE RENAL DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

d. HYPERTENSION

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: Cerebrovascular accident with (R) hemiparesis

**24a. WAS AN AUTOPSY PERFORMED?**: 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?**: 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?**: 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?**: 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Luis F. Gimenez MD

**29c. LICENSE NUMBER**: D31960

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5/9/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): LUIS F. GIMENEZ M.D.

**31. DATE FILED** (Month, Day, Year): MAY 12 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Pendarvis

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13069 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THOMAS LEE BOYER
2. DATE OF DEATH (Month, Day, Year): MAY 5 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212 10 6790A
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): AUG 26 03
8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): 11 HUNTING CREEK CT.
9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE
9c. COUNTY OF DEATH: BALTO

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTO
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11 HUNTING CREEK CT.
10f. ZIP CODE: 21228
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: W

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):
16b. KIND OF BUSINESS/INDUSTRY: LAUNDRY

17. FATHER'S NAME (First, Middle, Last): THOMAS BOYER
18. MOTHER'S NAME (First, Middle, Maiden Surname): CAROLINE COMEGYS

19a. INFORMANT'S NAME (Type/Print): NANCY ANN LUSTICA
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 HUNTING CREEK CT BALTO MD 21228

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ENTOMBMENT
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): H/N REDEEMER
20c. LOCATION — City or Town, State: BALTO MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward J Weber
22. NAME AND ADDRESS OF FACILITY: EDWARD J WEBER F.H. 5311 EDMONDSON AVE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cancer metastatic to liver, lung, heart — month
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Laurence R Gallagher MD
29c. LICENSE NUMBER: D01786
29d. DATE SIGNED (Month, Day, Year): ▶ 5-8-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LAURENCE R. GALLAGER, M.D. STAGNES MED CTR, WILKENSAUE. BALTO 21229

31. DATE FILED (Month, Day, Year): MAY 9 1989
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. XC 135 33 89 13070

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): AVON WULBERT BANNISTER | | | 2. DATE OF DEATH (Month, Day, Year): MAY 2 1989 | 3. TIME OF DEATH: 10:18 P. M |
| 4. SOCIAL SECURITY NUMBER: 218 05 2250 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10-25-14 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): VA MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: FORT HOWARD, MARYLAND | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1009 BENNETT PLACE | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SIGNET/MESSENGER | 16b. KIND OF BUSINESS/INDUSTRY: RETIRED |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): HENRY BANNISTER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE SMITH |
| 19a. INFORMANT'S NAME (Type/Print): FRANCES BANNISTER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1009 BENNETT PLACE/BALTO., MD 21223 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET CEM | 20c. LOCATION — City or Town, State: OWINGS MILLS, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. BILATERAL PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC MALNUTRITION, ATHEROSCLEROTIC HEART DISEASE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-4-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.V.J. VERGHESE, M.D. VA MEDICAL CENTER FORT HOWARD, MD 21052 | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall | |

DHMH-16 Rev 1/89

89 13071

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Fannie BAKER | | | 2. DATE OF DEATH (Month, Day, Year): May 10, 1989 | 3. TIME OF DEATH: 8:00p M |
| 4. SOCIAL SECURITY NUMBER: 213-14-3045 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/15/09 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Balto | 10c. CITY, TOWN OR LOCATION: Rosedale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 200 Choptank Ave | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White. |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home. | |
| 17. FATHER'S NAME (First, Middle, Last): Benjamin Franklin Houck | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Houck | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph F. Baker | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Choptank Ave Rosedale, Md 21237 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: Rosedale, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Rosedale F.H. 1211 Chesaco Ave 21237. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Septicemia. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Multiple decubiti ulcers. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease, Congestive heart failure, Metabolic acidosis.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CASE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. Wolff, MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 5-10-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marcos Wolff, M.D. 9000 Franklin Square Dr., Balto., 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 11 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13072
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary Margaret Blank | | | | 2. DATE OF DEATH (Month, Day, Year): May 3, 1989 | 3. TIME OF DEATH: 6 am M |
| 4. SOCIAL SECURITY NUMBER: 219-16-3046 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Aug. 29, 1923 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 12208 Timber Grove Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Owings Mills | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Owings Mills | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 12208 Timber Grove Road | | | 10f. ZIP CODE: 21117 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | | 16b. KIND OF BUSINESS/INDUSTRY: Maryland Cup Co. |
| 17. FATHER'S NAME (First, Middle, Last): James Farrell | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Donahue | | |
| 19a. INFORMANT'S NAME (Type/Print): Donald E. Blank | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12208 Timber Grove Rd., Owings Mills, Md. 21117 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. J. Eckhardt | | | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or reepiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Diabetes Mellitus — Atrial fibrillation
Hypothyroidism — Old Cerebrovascular Accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Gary A Manko MD | D25062 | ▶ 5-3-1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 11 E Chestnut Hill Ln, Reisterstown, MD 21136

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 5 '89 | Julia Davidson-Kendall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13073
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE V. BELLOS | | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 3 / 89 | | 3. TIME OF DEATH: 11 15 A M |
| 4. SOCIAL SECURITY NUMBER: 217-24-1160 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-25-28 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hosp. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | | 9c. COUNTY OF DEATH: BALTO. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Reisterstown | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 206 E. Cherry Hill Road | | 10f. ZIP CODE: 21136 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Food Vendor | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Harry Bellos | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Tacia Kapone | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia F. Bellos | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 E. Cherry Hill Rd. Reisterstown, Md. 21136 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem. | 20c. LOCATION — City or Town, State: Owings Mills, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank B. Eline | | 22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home Reisterstown, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D11171 | ▶ 5/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. P. WILLIAMSON — 5350 BALTO NAT'L PK BALTO, 21227 Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 9 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13074
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHESTER Francis BOWER | | | | 2. DATE OF DEATH MONTH 5 DAY 4 YEAR 89 | 3. TIME OF DEATH 1547 M | |
| 4. SOCIAL SECURITY NUMBER: 215-46-6411 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4/12/04 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Balto. Co. General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Randallstown | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 9071 Meadow Heights Road | | 10f. ZIP CODE: 21133 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fireman | 16b. KIND OF BUSINESS/INDUSTRY: Balto. City Fire Dept. | |
| 17. FATHER'S NAME (First, Middle, Last): Harry Bower | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Seaman | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Mildred Bower | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9071 Meadow Heights Road Randallstown, MD 21133 | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, MD 5/6/89 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Evans | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC CANCER OF PROSTATE | 0 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD | 29c. LICENSE NUMBER: D37333 | 29d. DATE SIGNED (Month, Day, Year): 5.4.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI BCGH, RANDALLSTOWN. | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13075 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNA MAY BUSH | | | 2. DATE OF DEATH (Month, Day, Year): 05 06 1989 | 3. TIME OF DEATH: 8:45 p M |
| 4. SOCIAL SECURITY NUMBER: 216-30-6768 | 5. SEX: 1 ☐ M 2 ☒ F | 8. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10/29/1934 | 6. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE Co. |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE Co. | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2904 VERMONT AVE, BALTIMROE | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th Grade; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mamager | 16b. KIND OF BUSINESS/INDUSTRY: Cue Club | | |
| 17. FATHER'S NAME (First, Middle, Last): EDWIN DUAN | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Louise SOHL | | |
| 19a. INFORMANT'S NAME (Type/Print): James E. Bush Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2904 Vermont Avenue Baltimore, Maryland 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | | 20c. LOCATION — City or Town, State: Glen Burnie, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C. Davis | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIO-PULMONARY COLLAPSE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. RECURRENT OVARIAN CANCER
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) ▶ 5/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G.H. Manlys MD 6701 NORTH CHARLES ST, TOWSON, MD 21204

31. DATE FILED (Month, Day, Year): MAY 8 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13076 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): ~~[illegible]~~ Sharon J. Berry

**2. DATE OF DEATH** Month: 05 Day: 15 Year: 89

**3. TIME OF DEATH**: 9.55 P M

**4. SOCIAL SECURITY NUMBER**: 202-36-5061

**5. SEX**: 1 ☐ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 41 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 12/27/47

**8. BIRTHPLACE** (State or Foreign Country): ~~USA~~ TENN

**9a. FACILITY NAME** (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSP.

**9b. CITY, TOWN OR LOCATION OF DEATH**: RANDALLSTOWN

**9c. COUNTY OF DEATH**: BALTO

**RESIDENCE OF DECEDENT**

**10a. STATE**: ~~MD~~ PA

**10b. COUNTY**: ~~BALTO~~ York

**10c. CITY, TOWN OR LOCATION**: GLEN ROCK

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☐ NO

**10e. STREET AND NUMBER**: Box 126 P

**10f. ZIP CODE**: 17327

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS** 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 0-12 — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Housewife

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Orval L. Moffitt

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Helen L. Jessee

**19a. INFORMANT'S NAME** (Type/Print): RAM NIMMAGADDA

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): BCGH Randallstown MD 21133

**20a. METHOD OF DISPOSITION** 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Hampstead Cemetery

**20c. LOCATION — City or Town, State**: Hampstead, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Jerry A. Eline

**22. NAME AND ADDRESS OF FACILITY**: Eline Funeral Home, Hampstead, Md. 21074

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE** (Final disease or condition resulting in death) → a. UPPER GASTRO INTESTINAL Bleeding

DUE TO (OR AS A CONSEQUENCE OF): b. ESOPHAGEAL VARICES

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**

DUE TO (OR AS A CONSEQUENCE OF): c. CIRRHOSIS OF LIVER

DUE TO (OR AS A CONSEQUENCE OF): d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

**27. MANNER OF DEATH** 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Ram Nimmagadda MD

**29c. LICENSE NUMBER**: BD 36612

**29d. DATE SIGNED** (Month, Day, Year): 5/15/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): RAM NIMMAGADDA BCGH RANDALLSTOWN MD 21133

**31. DATE FILED** (Month, Day, Year): MAY 18 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

OHMH-18 Rev 1/89

2

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13077 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carl Bruce
2. DATE OF DEATH (Month, Day, Year): May 20, 1989
3. TIME OF DEATH: 6:42 P M
4. SOCIAL SECURITY NUMBER: 219-18-9269
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/08/26
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Balto Co. General Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown
9c. COUNTY OF DEATH: Balto Co

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Randallstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 2108 Third Ave
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouseman
16b. KIND OF BUSINESS/INDUSTRY: Admin. Social Security
17. FATHER'S NAME (First, Middle, Last): James E. Bruce
18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace P. Wilson
19a. INFORMANT'S NAME (Type/Print): Pauline Bruce
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2108 Third Ave Balto, Md 21207
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veteran
20c. LOCATION — City or Town, State: Owings Mills, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Herbert E. Nutter
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Home Inc. Balto Co 2501 Gwynns Falls Parkway 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AS CVD with Coronary Insuff — 5 Yrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell MD
29c. LICENSE NUMBER: D-09383
29d. DATE SIGNED (Month, Day, Year): ▶ May 20, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell MD 7501 York Rd Towson 21204
31. DATE FILED (Month, Day, Year): MAY 25 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13078
REG. NO.

Zella Lilly Baldwin

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ZELLA BALDWIN | | | 2. DATE OF DEATH: MONTH 5 DAY 17 YEAR 89 | 3. TIME OF DEATH: 930 p M |
| 4. SOCIAL SECURITY NUMBER: 234 24 6661 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 26, 1915 | 8. BIRTHPLACE (State or Foreign Country): W. Va. |
| 9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, Md | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1112 Elbank Ave. | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical | 16b. KIND OF BUSINESS/INDUSTRY: Blue Cross/Blue Shield |
| 17. FATHER'S NAME (First, Middle, Last): Charles Wallace | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Logan | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Arthur L. Baldwin, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1112 Elbank Ave. Baltimore, Md. 21239 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Herman Dennis | | 22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchospasm — DUE TO (OR AS A CONSEQUENCE OF): — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. End Stage COPD — DUE TO (OR AS A CONSEQUENCE OF):

c. Atrial fibrillation — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph D'Antonio Jr. M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph D'Antonio Jr. M.D. 7401 Osler Drive Suite 210 Towson, Md 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13079

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Gustav S BIERWIRTH Sr.

**2. DATE OF DEATH** (Month, Day, Year): May 22, 1989

**3. TIME OF DEATH**: 7:00 p. M

**4. SOCIAL SECURITY NUMBER**: 217-38-3011

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 7-9-1911

**8. BIRTHPLACE** (State or Foreign Country): China

**9a. FACILITY NAME** (If not institution, give street and number): FRanklin Square Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore,Md.

**9c. COUNTY OF DEATH**: Baltimore County

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 11 Shawn Court

**10f. ZIP CODE**: 21236

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEOENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 2 yrs.

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Accountant

**16b. KIND OF BUSINESS/INDUSTRY**: Eastern Products

**17. FATHER'S NAME** (First, Middle, Last): Wilhelm Bierwirth

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Park

**19a. INFORMANT'S NAME** (Type/Print): Mary Theresa Bierwirth

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Shawn Court Baltimore,Md.-21236

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Parkwood Cemetery

**20c. LOCATION — City or Town, State**: Baltimore,Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Kathleen M. Murphy

**22. NAME AND ADDRESS OF FACILITY**: John C. Miller, Inc. 6415 Belair Road Baltimore,Md.-21206

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic Prostatic Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Bilateral Lower Lobe Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c. Dehydration
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**: Left Parietal Cerebrovascular Accident

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: D Green MD

**29c. LICENSE NUMBER**: N/A

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5/22/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Denise Green, M.D. 9000 Franklin Square Drive, 21237

**31. DATE FILED** (Month, Day, Year): MAY 24 1989

**32. REGISTRAR'S SIGNATURE**: Julie Tenison-Rudasa

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13080
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BESSIE BOOKER | | | | 2. DATE OF DEATH (Month, Day, Year): 5 19 89 | 3. TIME OF DEATH: 05:50 AM |
| 4. SOCIAL SECURITY NUMBER: 195-07-5827 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 94 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-9-1894 | 8. BIRTHPLACE (State or Foreign Country): KING WM. Ct, VA |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE CO. GENERAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: BALTO | 10c. CITY, TOWN OR LOCATION: | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 106 EAST AVE | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) ✓ / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CUSTODIAN | 16b. KIND OF BUSINESS/INDUSTRY: NAVAL DEPOT |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): JOSIAH ROANE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE TURNER |
| 19a. INFORMANT'S NAME (Type/Print): EDYTHE MASON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 EAST AVE BALTO 21222 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WILLIAM DAY CEM. | 20c. LOCATION — City or Town, State: HARRISBURG, PA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James A Morton | 22. NAME AND ADDRESS OF FACILITY: JAMES A MORTON 1701 LAURENS ST 21217 BALTO | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia Sepsis | 14 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gary L. Ko MD. | 29c. LICENSE NUMBER: D 22612 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/19/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Parker | | |

DHMH-16 Rev 1/89

89 13081

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Carmella M. Brunner
2. DATE OF DEATH: MONTH 05 DAY 19 YEAR 1989
3. TIME OF DEATH: 3:00 A M
4. SOCIAL SECURITY NUMBER: 214 18 9764
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 18, 1913
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 428 Overbrook Road
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Salvator Bognanni
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Colianni
19a. INFORMANT'S NAME (Type/Print): Mr. LeRoy Brunner, Jr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 428 Overbrook Road Baltimore, Md. 21212
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sherman Kenny Jr
22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | RESPIRATORY ARREST | 20' |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ASPIRATION OF STOMACH CONTENTS | 20' |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Septicemia from decubitus ulcers

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Alfonso MD
29c. LICENSE NUMBER: D29306
29d. DATE SIGNED (Month, Day, Year): 5/19/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALFONSO P. ZALDUONDO MD
31. DATE FILED (Month, Day, Year): MAY 22 1989
32. REGISTRAR'S SIGNATURE: Julia Dawson Kendall

DHMH-16 Rev 1/89

89 13081

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13082

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Item: 3 per DR 0658 12-19-89 cm

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Paul Andrew Brown
2. DATE OF DEATH (Month, Day, Year): May 17 1989
3. TIME OF DEATH: 11:35p M
4. SOCIAL SECURITY NUMBER: 214-07-5078
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 87 YRS.
   IF UNDER 1 YEAR: MONTHS / DAYS
   IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 14 1901
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Cockeysville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2 Nutmeg Knoll Court, Apt. A
10f. ZIP CODE: 21030
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES [X] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 14
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auditing Acct/Comptroller
16b. KIND OF BUSINESS/INDUSTRY: Accounting
17. FATHER'S NAME (First, Middle, Last): William Brown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Sullivan
19a. INFORMANT'S NAME (Type/Print): Doris B. Wilson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Nutmeg Knoll Ct., Apt. A, Cockeysville, Md. 21030
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Colon CA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D19166
29d. DATE SIGNED (Month, Day, Year) ▶ 5/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Alan Baldanza, 10629 York Rd., Cockeysville, Md. 21030
31. DATE FILED (Month, Day, Year): MAY 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DHMH-18 Rev 1/89

89 13083

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be filed within 72 hours after death as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): JAMES J. BRAZITIS
2. DATE OF DEATH (Month, Day, Year): May 4, 1989
3. TIME OF DEATH: 5:20 A M
4. SOCIAL SECURITY NUMBER: 212-62-6177
5. SEX: 1 ☐ M 2 ☐ F — XX
6. AGE (In yrs. last birthday): 37 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 25, 1951
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore County
10c. CITY, TOWN OR LOCATION: Parkville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO — XX
10e. STREET AND NUMBER: 3027 Lavender Ave.
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced — XX
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES — XX
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO — XX — Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years — College (1-4 or 5+): ----------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Social Security Admin.
17. FATHER'S NAME (First, Middle, Last): Joseph A. Brazitis
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann J. Urbanas
19a. INFORMANT'S NAME (Type/Print): Joseph A. Brazitis
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3027 Lavender Ave. Baltimore, MD 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) — XX
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Saint Casimeir's Cemetery
20c. LOCATION — City or Town, State: Muhlenburg, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiomyopathy, Idiopathic Dilated | 3 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Duane Smoot MD
29c. LICENSE NUMBER: D31831
29d. DATE SIGNED (Month, Day, Year): ▶ 5/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Duane Smoot MD 7620 York Road Towson MD 21204
31. DATE FILED (Month, Day, Year): MAY 5 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

98 13083

89 13084

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM E. BUTTS | | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 16 / 89 | 3. TIME OF DEATH: 12:45 A M |
| 4. SOCIAL SECURITY NUMBER: 220-03-5443 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-12-21 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, MD 21204 | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: #909 500 Virginia Ave. | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [XX] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years; College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Louis M. Butts, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Leona C. Phillips | |
| 19a. INFORMANT'S NAME (Type/Print): Carleen Mae Rapp | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 519 Murdell Lane Livermore, California 94550 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park | 20c. LOCATION — City or Town, State: Balto.Co., Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Previous myocardial Infarction

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 26d. DESCRIBE HOW INJURY OCCURED | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Marian C. Kowalewski MD | 29c. LICENSE NUMBER: D21022 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARION C. KOWALEWSKI MD 8604 HARFORD Rd 21234

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dodson-Lindsey |

DHMH-16 Rev 1/89

89 13085

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Mary Ellen BARBER
2. DATE OF DEATH (Month, Day, Year): May 2, 1989
3. TIME OF DEATH: 12:02 A M
4. SOCIAL SECURITY NUMBER: 215-48-1556
5. SEX: 1 ☐ M 2 ☑ F
5. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 8, 1911
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANKLYN SQUARE HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: ROSEDALE
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: PERRY HALL, MD. 5212 SILVER SPRING RD. 21128
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5212 SILVER SPRING ROAD
10f. ZIP CODE: 21128
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MOTEL OPERATOR
16b. KIND OF BUSINESS/INDUSTRY: TOURIST
17. FATHER'S NAME (First, Middle, Last): JOHN KIRKCHOFF
18. MOTHER'S NAME (First, Middle, Maiden Surname): MINNIE AULT
19a. INFORMANT'S NAME (Type/Print): HARRY P. BARBER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BALDWIN MD. 5520 SWEET AIRRD. 21013
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EVERGREEN MEMORIAL GARDENS
20c. LOCATION — City or Town, State: FINKSBURG, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Myers
22. NAME AND ADDRESS OF FACILITY: MYERS FUNERAL HOME WESTMINSTER 91 MILLS ST., MD

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Encephalopathy
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Hagan M.D.
29c. LICENSE NUMBER: D37242
29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Hagan, M.D. 9000 Franklin Square Drive, Baltimore 21237
31. DATE FILED (Month, Day, Year): MAY 4 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

88 13082

89 13086

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lloyd W BELL | | | | 2. DATE OF DEATH: MONTH May DAY 5, YEAR 1989 | 3. TIME OF DEATH: 11:55 PM | |
| 4. SOCIAL SECURITY NUMBER: 215-05-5025 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): NOV. 11, 1912 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD. | | 9c. COUNTY OF DEATH: Baltimore County | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | | 10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 426 ELMWOOD ROAD | | | 10f. ZIP CODE: 21206 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR | | 16b. KIND OF BUSINESS/INDUSTRY: PAUL JONES, INC. | |
| 17. FATHER'S NAME (First, Middle, Last): ROBERT BELL | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MAUDE ? | | | |
| 19a. INFORMANT'S NAME (Type/Print): IRENE BELL | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 426 ELMWOOD ROAD BALTIMORE, MD. 21206 | | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 8 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY | | 20c. LOCATION — City or Town, State: BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marlin J. Dippel, Jr. | | | 22. NAME AND ADDRESS OF FACILITY: DIPPEL FUNERAL HOME, INC. 7110 BELAIR ROAD BALTO. MD. 21206 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Asystole | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal Cell Carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| P Joyce MD | N/a | ▶ 5-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patrick Joyce MD. 9000 Franklin Square Drive 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 9, 1989 | Ella Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13087 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNA BOUREK | | | | 2. DATE OF DEATH (Month, Day, Year): MAY 5 1989 | 3. TIME OF DEATH: 11:30 P.M |
| 4. SOCIAL SECURITY NUMBER: 215-32-5907-D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan. 16 1898 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center-Cromwell | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore Co. |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: --- | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 815 N. Kenwood Avenue | | 10f. ZIP CODE: 21205 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Albert Zelenka | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Michakek | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Bourek (son) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 815 N. Kenwood Ave., Baltimore, Md. 21205 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Redeemer | | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerosis | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D20673 | ▶ 5/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. George Lowe 3703 Belair Rd. Baltimore, Md. 21213

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 9 1989 | Julia Davidson-Randall |

DHMN-16 Rev 1/89

89 13088

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEROY WAYNE BASKETTE | | | 2. DATE OF DEATH (Month, Day, Year): 5 4 89 | 3. TIME OF DEATH: 5:05 PM |
| 4. SOCIAL SECURITY NUMBER: 218-46-5415 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-19-45 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): STELLA MARIS HOSPICE | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON Towson | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 200 Wampler Road | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): --- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist | 16b. KIND OF BUSINESS/INDUSTRY: Westinghouse | |
| 17. FATHER'S NAME (First, Middle, Last): Roland G. Baskette | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Emma Vogt | | |
| 19a. INFORMANT'S NAME (Type/Print): Cheryl Ann Baskette | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Wampler Road 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery | 20c. LOCATION — City or Town, State: Baltimore City, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC MELANOMA | 5 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) HOSPICE | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28d. DESCRIBE HOW INJURY OCCURED | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carla A Alexandero | 29c. LICENSE NUMBER: D27087 | 29d. DATE SIGNED (Month, Day, Year): 5-4-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Yr.): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13089
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James C. BAUCOM | | | 2. DATE OF DEATH (Month, Day, Year): May 5 1989 | 3. TIME OF DEATH: 12:25 P M |
| 4. SOCIAL SECURITY NUMBER: 241 01 6064 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 8, 1913 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville 21237 | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1804 Kitty Hawk Road | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Crane Operator | 16b. KIND OF BUSINESS/INDUSTRY: Steel Co. | |
| 17. FATHER'S NAME (First, Middle, Last): William M. Baucom | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Tucker | |
| 19a. INFORMANT'S NAME (Type/Print): Helen P. Baucom Wife | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1804 Kitty Hawk Road 21221 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens Of Faith Cemetery | 20c. LOCATION — City or Town, State: Baltimore County, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. 21221 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ischemic Cardiomyopathy | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial Infarction | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): May 5 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patrick Joyce, M.D. 9000 Franklin Sq. Dr. 21237 | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13090 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BERNARD J. BAKER | | | 2. DATE OF DEATH Month 5 Day 7 Year 89 | 3. TIME OF DEATH 2:45 A M |
| 4. SOCIAL SECURITY NUMBER 213 07 2917 | 5. SEX 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday) 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 1, 1911 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE Md. | 10b. COUNTY Baltimore | 10c. CITY, TOWN OR LOCATION Essex | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER 1209 Engelberth Road | | 10f. ZIP CODE 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 9 College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder | 16b. KIND OF BUSINESS/INDUSTRY Construction | | |
| 17. FATHER'S NAME (First, Middle, Last) Michael Baker | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Magdeline Lubinski | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elizabeth . Baker (Wife) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Engelberth Road 21221 | | | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens Of Faith Cemetery | 20c. LOCATION — City or Town, State Baltimore County, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. 21221 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADENOCARCINOMA OF THE PANCREAS | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. WITH METASTASES. | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. RENAL FAILURE | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. ANEMIA | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ceballos, MD | D 25886 | ▶ 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CEBALLOS, M.D. - ST. JOSEPH HOSPITAL. - TOWSON, MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 9 1989 | Julia Davidson-Nichols |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13091

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ELEANOR | ANN | BEACHLER | 5 13 89 | 5:40 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-84-5684 | 1 ☐ M 2 ☒ F | 65 YRS. | | | 11/19/23 | Mass. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| GREATER BALTIMORE MEDICAL CTR. | TOWSON. MD 21204 | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltim ore | Towson | 1 ☐ YES 2 ☒ HO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 404 Terrace Way | 21204 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDEHT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Ho— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ HO | 1 ☐ YES 2 ☒ HO Specify: | Specify: White |

| 15. DECEDEHT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIHD OF BUSIHESS/IHDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 years | | Antique Dealer | Antiques |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Jared Barton Fleming | Marguerite Brumley |

| 19a. IHFORMANT'S HAME (Type/Print) | 19b. MAILIHG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| William M. Beachler | 404 Terrace Way Towson, Maryland 21204 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Dulaney Valley Memorial Gard. | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AHD ADDRESS OF FACILITY |
|---|---|
| Lasseter Funeral Home | 7401 Belair Road Baltimore, Maryland 21236 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOPULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. LEFT LOWER LOBE PNEUMINIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): LUNG CANCER | |
| | c. DUE TO (OR AS A CONSEQUEHCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ HO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMIHER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ HO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MAHHER OF DEATH | 28a. DATE OF IHJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ HO | |
| | 28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIHG PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGHATURE AHD TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGHED (Month, Day, Year) |
|---|---|---|
| Rezazadeh M.D. | | ▶ 5/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HAMIED REZAZADEH M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGHATURE |
|---|---|
| MAY 17 1989 | Julia Davidson-Landrum |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13092 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jane C. Bull | | | 2. DATE OF DEATH (Month, Day, Year): 5 26 89 | 3. TIME OF DEATH: 9:05 A. M |
| 4. SOCIAL SECURITY NUMBER: 212-05-3180- A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11/29/09 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Manor Care - Towson | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Balto. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Cockeysville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1807 Miller Rd. | 10f. ZIP CODE: 21030 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2Yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Friends School |
| 17. FATHER'S NAME (First, Middle, Last): Louis Curlett | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Balke | |
| 19a. INFORMANT'S NAME (Type/Print): John F. Bull | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1807 Miller Rd. Cockeysville, Md. 21030 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald E. Ruck Jr. | | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. 21204 Towson, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

c. diabetes mellitus

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

advanced dementia

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|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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| 29b. SIGNATURE AND TITLE OF CERTIFIER: Henri T. Voorstad M.D. | 29c. LICENSE NUMBER: D 11064 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5.26.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henri T. Voorstad M.D. 7600 Osler Dr. Towson, Md. 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): JUN 01 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Grandell |

DHMH-18 Rev 1/89

89 13093

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Emma Ella Marie Bashore | | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 25 / 89 | 3. TIME OF DEATH: 5:30 A.M |
| 4. SOCIAL SECURITY NUMBER: 213-38-5768 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/8/1902 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 601 Marwood Rd. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Balto. |

RESIDENCE OF DECEDENT

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|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Balto. | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 601 Marwood Rd. | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 6 Yr's | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Balto. Co. Schools | |
| 17. FATHER'S NAME (First, Middle, Last): John Teipe | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabella C. Gocking | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph Teipe | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5009 Tulip Ave. Balto. Md. 21227 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery 5/26/89 | 20c. LOCATION — City or Town, State: Balto. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald E. Schafer Sr. | | 22. NAME AND ADDRESS OF FACILITY: 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD — DUE TO (OR AS A CONSEQUENCE OF): — years

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert E. Stoner | 29c. LICENSE NUMBER: D13272 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert E. Stoner M.D. 120 Sister Pierre Dr. Towson, Md. 21204 | | |
| 31. DATE FILED (Month, Day, Year): JUN 01 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

Cecelia M. Baker

89 13094

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BAKER CECELIA | | | 2. DATE OF DEATH (Month, Day, Year): 05 13 1989 | 3. TIME OF DEATH: 5:50 AM |
| 4. SOCIAL SECURITY NUMBER: 213-09-7249 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/18/1909 | 8. BIRTHPLACE (State or Foreign Country): USA |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY Gen. Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN, MD | | 9c. COUNTY OF DEATH: BALTO |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTO | 10c. CITY, TOWN OR LOCATION: TANEYTOWN | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3217 BERKOWITZ Rd. | 10f. ZIP CODE: 21787 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White. |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook | 16b. KIND OF BUSINESS/INDUSTRY: High School Cafe. | |
| 17. FATHER'S NAME (First, Middle, Last): John Kraemer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Dunnigan. | |
| 19a. INFORMANT'S NAME (Type/Print): RAM NIMMAGADDA | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BCGH, RANDALLSTOWN MD 21133 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery | 20c. LOCATION — City or Town, State: Balto. City | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] CRD | 22. NAME AND ADDRESS OF FACILITY: Rosedale Funeral Home 1211 Chesaco Ave. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CELLULITIS (R) LOWER EXTREMITY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. FRACTURED SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. SMALL BOWEL OBSTRUCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DEMENTIA | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA
PNEUMONITIS

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ram Nimmagadda MD | 29c. LICENSE NUMBER: BD 36612 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/13/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BCGH. Randalls Town MD 21133 | | |
| 31. DATE FILED (Month, Day, Year): 5/13/89 MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Pendarvis | |

DHMH-16 Rev 1/89

2

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13095
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Christian P. Bichell, Sr. Christian BICHELL | | | 2. DATE OF DEATH (Month, Day, Year): May 14 1989 | 3. TIME OF DEATH: 2:45 p M |
| 4. SOCIAL SECURITY NUMBER: 212-10-9931 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan 2, 1901 | 8. BIRTHPLACE (State or Foreign Country): Baltimore, MD. |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville, Maryland | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Overlea | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 16 Glade Avenue | | 10f. ZIP CODE: 21236 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Building Manager | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government | |
| 17. FATHER'S NAME (First, Middle, Last): Geroge P. Bichell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Meyers | |
| 19a. INFORMANT'S NAME (Type/Print): Christian P. Bichell, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12021 Brooknoll Drive Kingsville, MD 21087 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J. Dippel Jr | | 22. NAME AND ADDRESS OF FACILITY: DIPPEL FUNERAL HOME, INC 7110 Belair Road Baltimore, MD 21206 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Status Post Cerebral Vascular Accident

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M. Wolff, MD | | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): May 14, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marcus Wolff 9000 Franklin Square Drive, Baltimore 21237 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill | | |

DHMH-16 Rev 1/89

89 13096

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH CARL BUETTNER, SR. | | | 2. DATE OF DEATH (Month, Day, Year): May 19, 1989 | 3. TIME OF DEATH: 6:10 PM |
| 4. SOCIAL SECURITY NUMBER: 216-05-5594 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jun 20, 1914 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 1700 Orlando Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Parkville | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Parkville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1700 Orlando Road | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Years; College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman | 16b. KIND OF BUSINESS/INDUSTRY: Grocery | |
| 17. FATHER'S NAME (First, Middle, Last): Frederick M. Buettner | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alma L. Simms | |
| 19a. INFORMANT'S NAME (Type/Print): Mary E. Buettner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1700 Orlando Rd. Baltimore, Maryland 21234 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Balto. Co., Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. towson, MD 21204 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Widespread metastatic Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus
CVA

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D05425 | 29d. DATE SIGNED (Month, Day, Year): 5/20/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1900 E. Northern Parkway Baltimore MD 21239 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 13097

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donna Byers | | | | | 2. DATE OF DEATH: MONTH 5 DAY 25 YEAR 89 | 3. TIME OF DEATH: 9:40 A M |
| 4. SOCIAL SECURITY NUMBER: 208-03-0313 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-29-1912 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): 7934 Dunhill Village Circle | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockdale | | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | | 10c. CITY, TOWN OR LOCATION: Rockdale | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 7934 Dunhill Village Circle Apt 102 | | | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): -- | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: -- | |
| 17. FATHER'S NAME (First, Middle, Last): Todd D. Brewster | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mazie Fredonia Blakeley | | | |
| 19a. INFORMANT'S NAME (Type/Print): Col. Charles V. Byers | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7934 Dunhill Village Circle Baltimore, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery | | 20c. LOCATION — City or Town, State: Arlington, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John K Aymold | | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Rd. Randallstown, MD 21133 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| E. P. Williamson MD for Dr. of Path | D11171 | ▶ 5/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. P. WILLIAMSON MD - 5550 BALTIMORE NAT'L PK - CATONSVILLE - 21228. MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13098 REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Frances E. Bildstein | | | 2. DATE OF DEATH (Month, Day, Year) 5-25-1989 | 3. TIME OF DEATH 703 P M |
| 4. SOCIAL SECURITY NUMBER 023-14-0499 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 9-30-28 | 8. BIRTHPLACE (State or Foreign Country) Boston |
| 9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson | | 9c. COUNTY OF DEATH Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Md. | 10b. COUNTY Carroll County | 10c. CITY, TOWN OR LOCATION Mt. Airy | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 4637 Roop Rd. | | 10f. ZIP CODE 21771 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator | 16b. KIND OF BUSINESS/INDUSTRY Social Security | |
| 17. FATHER'S NAME (First, Middle, Last) Mc Ginnis | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown | |
| 19a. INFORMANT'S NAME (Type/Print) Mr. John R. Bildstein | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4637 Roop Rd. Mt. Airy. Md. 21771 | |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory | 20c. LOCATION — City or Town, State Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hartley Miller | | 22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Low Cardiac Output Syndrome | Hours |
| | DUE TO (OR AS A CONSEQUENCE OF): Long Standing Coronary Artery Disease | Years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiac Surgery. CABG x 5

Diabetes, Hypertension, Atrial Fibrillation

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 6 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Garth R. McDonald MD Attending Surgeon | | ▶ 5.25.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Garth R. McDonald c/- Saint Joseph Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 13038

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13099

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAYMOND MURRAY CUNNINGHAM, M.D. | | | | 2. DATE OF DEATH (Month, Day, Year): 5 6 89 | 3. TIME OF DEATH: 9:28 A M |
| 4. SOCIAL SECURITY NUMBER: 215-10-6065 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 02-02-1912 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CTR. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: TIMONIUM | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 48 MERRION COURT | | 10f. ZIP CODE: 21093 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Surgeon | 16b. KIND OF BUSINESS/INDUSTRY: Medical |
| 17. FATHER'S NAME (First, Middle, Last): RAYMOND A. CUNNINGHAM | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE MURRAY | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret R. Cunningham | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 48 Merrion Court, Timonium, Md. 21093 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens | 20c. LOCATION — City or Town, State: Timonium, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martin D. Lawson | | 22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CONGESTIVE HEART FAILURE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ISCHEMIC HEART DISEASE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James H. Biddison M.D. | 29c. LICENSE NUMBER: D15561 | 29d. DATE SIGNED (Month, Day, Year): 5/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES BIDDISON M.D. 6701 N. CHARLES ST, BALTIMORE, MD 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall |

DHMH-18 Rev 1/89

89 13100

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET A. COSTENBADER | | | 2. DATE OF DEATH (Month, Day, Year): May 5 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 220-12-9311 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Sept. 27, 1914 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): 4006 Old North Point Rd. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4006 Old North Point Road | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 3 years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse | 16b. KIND OF BUSINESS/INDUSTRY: Balto. City Hospital |
| 17. FATHER'S NAME (First, Middle, Last): John Logan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Carey | |
| 19a. INFORMANT'S NAME (Type/Print): Earl A. Costenbader | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4006 Old North Point Rd Balto., Md. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mausoleum | 20c. LOCATION — City or Town, State: Timonium, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Colline | | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC LUNG CANCER | 6 MO |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D35606 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/7/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RONDA SUTTON MD 711 W 40 ST BALT MD 21211 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dondon-Rudasa | | |

DHMH-18 Rev 1/89

88 13100

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13101
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Cleopatra K. CARDIGES | | | 2. DATE OF DEATH (Month, Day, Year): May 19, 1989 | 3. TIME OF DEATH: 8:35 PM |
| 4. SOCIAL SECURITY NUMBER: 215-07-4033 D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-20-08 | 8. BIRTHPLACE (State or Foreign Country): Greece |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore, County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8913 Lennings Lane | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: - | |
| 17. FATHER'S NAME (First, Middle, Last): Kelianopoulos | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Kiki | |
| 19a. INFORMANT'S NAME (Type/Print): Helen S. Angelos | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8913 Lennings Lane, Baltimore, Md. 21237 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greek Orthodox Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ann S. Matthews | | 22. NAME AND ADDRESS OF FACILITY: Matthews Funeral Home 3021 Eastern Avenue, Baltimore, Md. 21224 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebro-Vascular Accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul I. Wielebinski MD | 29c. LICENSE NUMBER: D33719 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Wielebinski, M.D. 9000 Franklin Square Dr., Baltimore 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers |

DHMH-18 Rev 1/89

89 1310

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13102

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Raymond I. Crawford
2. DATE OF DEATH (Month, Day, Year): 05 13 89
3. TIME OF DEATH: 12:55p M
4. SOCIAL SECURITY NUMBER: 213-28-7142
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/20/31
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Greater BaLtimore Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Maryland
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baldwin
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10a. STREET AND NUMBER: 2805 Shady Grove Court
10f. ZIP CODE: 21013
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Korean
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive Officer, Pres.
16b. KIND OF BUSINESS/INDUSTRY: Trucking Company
17. FATHER'S NAME (First, Middle, Last): Raymond Ira Carlise Crawford, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Elise Caskey
19a. INFORMANT'S NAME (Type/Print): Yvonne M. Crawford
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2805 Shady Grove Court, Baldwin, Md. 21013
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Highview Memorial Park
20c. LOCATION — City or Town, State: Baldwin, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martin D. Lawson
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd., Timonium, Md. 21093

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio Pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. VENTRICULAR FIBRILLATION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. PROBABLE MYOCHROIAL INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert H. Wiedefeld MD
29c. LICENSE NUMBER: D33011
29d. DATE SIGNED (Month, Day, Year): 5-15-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert H. Wiedefeld, M.D. — Greater Baltimore Medical Center — 6701 North Charles Street — 21204
31. DATE FILED (Month, Day, Year): MAY 17 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

23 +1

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13103
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Doris L CARROLL | 2. DATE OF DEATH (Month, Day, Year): May 27, 1989 | 3. TIME OF DEATH: 6:40 A M | |
| 4. SOCIAL SECURITY NUMBER: 213 20 0477 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 31, 1925 |
| 8. BIRTHPLACE (State or Foreign Country): Balto Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore County | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1517 Williams Ave. | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Claude Whitcock | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dessie Robinette | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Carroll, Son | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 652 Middlesex Rd. Balto., Md. 21221 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens | 20c. LOCATION — City or Town, State: Baltimore Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bruzdzinski | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto Md. 21221 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic Small Cell Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c. Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Laurie Herscher 9000 Franklin Square Drive Baltimore, MD 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

88 13103

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13104

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Margaret W CALLENDER | | | | 2. DATE OF DEATH (Month, Day, Year): May 19, 1989 | 3. TIME OF DEATH: 3:00 AM M |
| 4. SOCIAL SECURITY NUMBER: 212-50-7485 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 94 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-1-1895 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: ROSSVILLE | | 9c. COUNTY OF DEATH: Baltimore County |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7476 RABON AVENUE | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 TH GRADE; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER | | 16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC | |
| 17. FATHER'S NAME (First, Middle, Last): HUGH F. HAMILL | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): WILHEMINA TIDIMANN | |
| 19a. INFORMANT'S NAME (Type/Print): GEORGE J. CALLENDER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7476 RABON AVENUE BALTIMORE, MARYLAND 21222 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER CEMETERY 5-22-89 | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles W. Fisher | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Decubitus Ulcer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Dehydration | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | N/A | ▶ 5/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Laurie Herscher MD. 9000 Franklin Square Drive 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 23 1989 | Julia Gordon-Pinder |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13105 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VESTA MAY CARY | | | 2. DATE OF DEATH (Month, Day, Year): May 17, 1989 | 3. TIME OF DEATH: 6:05 P,M. M |
| 4. SOCIAL SECURITY NUMBER: 218-32-4506 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 19, 1899 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Broadmead | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville, | | 9c. COUNTY OF DEATH: Baltimore |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 10 Choate Ct. | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner | 16b. KIND OF BUSINESS/INDUSTRY: Children's Shop | |
| 17. FATHER'S NAME (First, Middle, Last): William E. Litchfield | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Bowland | |
| 19a. INFORMANT'S NAME (Type/Print): Bette Rae Cary | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem.Gdns.5/19/89 | 20c. LOCATION — City or Town, State: Timonium, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MULTIPLE CEREBROVASCULAR ACCIDENTS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ARTERIOSCLEROSIS & CARDIOVASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS TYPE II
HYPERTENSION

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY M / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Walter Hanig MD | 29c. LICENSE NUMBER: D23450 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Gordon-Pinder |

OHMH-16 Rev 1/89

88 13102

89 13106

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helena B. CRONE | | | 2. DATE OF DEATH (Month, Day, Year): May 13, 1989 | 3. TIME OF DEATH: 5:00 p M |
| 4. SOCIAL SECURITY NUMBER: 212-03-7847 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 3, 1901 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5096 Orville Avenue | | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): John T. Crone | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Eva Jacob | |
| 19a. INFORMANT'S NAME (Type/Print): AUGUST J. CRONE- BROTHER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5016 Erdman Avenue, Balto, Md. 21205 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: Balto, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian D. Lewis | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME 3331 Brehms Lane, Balto. Md. 21213 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pancreatitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| R. A. Richards MD - House Officer | N/A | ▶ 5-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rose Richards MD. 9000 Franklin Square Dr. Balto, Md. 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | Julia Davidson-Landers |

DHMH-18 Rev 1/89

30161 68

2

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13107
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Patricia A. Carr | | | 2. DATE OF DEATH MONTH 5 DAY 7 YEAR 89 | 3. TIME OF DEATH 445A M |
| 4. SOCIAL SECURITY NUMBER: 215-54-1567 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (in yrs. last birthday): 38 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4/26/51 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): ST Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 9029 Hines Road | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Harry T. Schreck | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen L. Madigan | |
| 19a. INFORMANT'S NAME (Type/Print): Harry M. Schreck, | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9029 Hines Road, Baltimore, Maryland, 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park 5-8-89 | 20c. LOCATION — City or Town, State: Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Rd. Balto. Md. 21214 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatic Coma | 36 hrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute Hepatitis | 48 hrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Heroin Addiction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Mark Hall | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DNMN-16 Rev 1/89

2

89 1310J

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13108
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN W. CRAWFORD | | | | | 2. DATE OF DEATH (Month, Day, Year): 5 5 89 | 3. TIME OF DEATH: 03.30 AM |
| 4. SOCIAL SECURITY NUMBER: 217-20-9467 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7/29/26 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Balto. Co. General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3207 Mayfield Avenue | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Heavy Equipment Operator | 16b. KIND OF BUSINESS/INDUSTRY: Local #37 | |
| 17. FATHER'S NAME (First, Middle, Last): John Wilbur Crawford, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Belle Day | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Charlotte W. Crawford | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3207 Mayfield Ave. Baltimore, MD 21207 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery 5/8/89 | 20c. LOCATION — City or Town, State: Pikesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J Byrne | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cerdiec or respiretory srrest, shock, or heert failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ca. of Lung | DUE TO (OR AS A CONSEQUENCE OF): | 7 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. | DUE TO (OR AS A CONSEQUENCE OF): | |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] M.D. | 29c. LICENSE NUMBER: D22612 | 29d. DATE SIGNED (Month, Day, Year): 5/5/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] | | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | | |

DHMH-16 Rev 1/89

88 13108

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13109
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Louise Campagnoli — Mary Campagnol,
2. DATE OF DEATH: Month: May; Day: 1; Year: 89
3. TIME OF DEATH: 1:20 PM
4. SOCIAL SECURITY NUMBER: 216-07-0306
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 7-2-15
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital - 7620 York Rd. Towson, Md
9b. CITY, TOWN OR LOCATION OF DEATH
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Fallston,
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2410 Rochelle Dr.
10f. ZIP CODE: 21047
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 Separated ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: NO
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker
16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): Charles Ferraro
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Cuneo
19a. INFORMANT'S NAME (Type/Print): Mary Lou Leimbach-Dghtr
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2410 Rochelle Drive, Fallston, Md. 21047
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deth. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ~~Arrest~~ error Rupture, Left ventricle wall | minutes |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Acute myocardial infarction | days |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Coronary thrombosis | days |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Arteriosclerosis | years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Polycythemia vera

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D17966
29d. DATE SIGNED (Month, Day, Year): ▶ 1 MAY 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAURICE B FURLONG JR MD / St Joseph Hospital
31. DATE FILED (Month, Day, Year): MAY 4 - 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13110

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN ROSE CARE | | | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 1 / 89 | 3. TIME OF DEATH: 2:30 A M |
| 4. SOCIAL SECURITY NUMBER: 233-18-3036 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): OCT. 9, 1905 | 8. BIRTHPLACE (State or Foreign Country): ROME, OHIO |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: – | 10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6401 SEFTON AVENUE | | 10f. ZIP CODE: 21214 | 10g. CITIZEN OF WNAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): – | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HAIRSTYLIST | 16b. KIND OF BUSINESS/INDUSTRY: HAIR STYLING | |
| 17. FATHER'S NAME (First, Middle, Last): ALFRED SHERMAN BEVAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CYNTHIA ANN | |
| 19a. INFORMANT'S NAME (Type/Print): ELIZABETH ANN CONCO | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6401 SEFTON AVENUE BALTIMORE, MD 21214 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODMERE MEMORIAL PARK | 20c. LOCATION — City or Town, State: HUNTINGTON W. VA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J Dippel Jr | | 22. NAME AND ADDRESS OF FACILITY: DIPPEL FUNERAL HOME 7110 BELAIR ROAD BALTIMORE, MD. 21206 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. END STAGE CONGESTIVE HEART FAICURE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD - ANGINA | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. S/P LEFT CAROTID ENDARTERECTOMY | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. VENTRICULAR DYSRHYTHMIA. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ceballos, M.D. | 29c. LICENSE NUMBER: D25886 | 29d. DATE SIGNED (Month, Day, Year): 5/1/89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CEBALLOS M.D. – ST. JOSEPH HOSPITAL - TOWSON, MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13111

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mazie A. COSTENBADER | | | 2. DATE OF DEATH (Month, Day, Year): May 5, 1989 | 3. TIME OF DEATH: 7:15 A M |
| 4. SOCIAL SECURITY NUMBER: 209-20-7895 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov. 2 1895 |
| 8. BIRTHPLACE (State or Foreign Country): Penna. | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore County | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Pa. | 10b. COUNTY: -- | 10c. CITY, TOWN OR LOCATION: Palmerton | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: R. D. 1, | 10f. ZIP CODE: 18071 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO; IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Edwin Green | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Kintz | | |
| 19a. INFORMANT'S NAME (Type/Print): Franklin Costenbader (son) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.D. 1, Palmerton, Penna. 18071 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Towamensing Cemetery | 20c. LOCATION — City or Town, State: Palmerton, Penna. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21213 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | e. Malignant Lymphoma | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Bacturemia | |
| | c. | |
| | d. | |

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Left Cerebrovascular Accident

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Denise Green | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Denise Green, M.D. 9000 Franklin Sq. Dr. 21237 | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13112 REG. NO.

64

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GERARD D. CARTER
2. DATE OF DEATH: MONTH 5 DAY 12 YEAR 89
3. TIME OF DEATH: 2⁴⁰ P M
4. SOCIAL SECURITY NUMBER: 213-26-8077
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-12-31
8. BIRTHPLACE (State or Foreign Country): USA
9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: BALT. (RANDALSTOWN)
9c. COUNTY OF DEATH: BALT.

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3739 DOLFIELD AVE.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSTRUCTION INSPECTOR
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Walter R. Carter
18. MOTHER'S NAME (First, Middle, Maiden Surname): Olivia Harrid
19a. INFORMANT'S NAME (Type/Print): Melvin Carter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 835 Woodbourne
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet
20c. LOCATION — City or Town, State: Owings Mills, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: March F.H. West 4300 Wabash Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Renal Cancer — left kidney
DUE TO (OR AS A CONSEQUENCE OF):
b. Liver & Lung Metastasis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William L Yap MD
29c. LICENSE NUMBER: D 31256
29d. DATE SIGNED (Month, Day, Year) ▶ 5-12-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William L. YAP M.D.
31. DATE FILED (Month, Day, Year): MAY 15 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Pendarvis

DHMH-16 Rev 1/89

88 13115

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13113 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

R (Pages 1, 2, 3 should)

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lawrence E. Dring Sr. | | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 5 / 89 | 3. TIME OF DEATH: 10:42 AM |
| 4. SOCIAL SECURITY NUMBER: 212-46-7737 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 43 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 09-26-45 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena, | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7748 West Shore Road | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Utility Contractor | 16b. KIND OF BUSINESS/INDUSTRY: Self Employed L. E. Dring Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Bertram Dring | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marjorie F. Roszenski | |
| 19a. INFORMANT'S NAME (Type/Print): Cherie Dring | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7748 West Shore Dr., Pasadena, MD 21122 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Memorial Gardens | 20c. LOCATION — City or Town, State: Davidsonville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert Gregory Bahm | | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, Maryland 21061 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5/5/89 | 28b. TIME OF INJURY: 9:59A M | 28c. INJURY AT WORK? 1 ☒ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: trench caved in on subject | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): work site | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): A.A.CO, MD 5600 Blk. Harbor Valley Drive |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D., Acting Deputy Chief 111 Penn St. Balto.MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13114 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY ELLEN COX
2. DATE OF DEATH (Month, Day, Year): 5-15-1989
3. TIME OF DEATH: 12:48 A. M
4. SOCIAL SECURITY NUMBER: 214-14-7793
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 76 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-24-1912
8. BIRTHPLACE (State or Foreign Country): N.Y.
9a. FACILITY NAME (If not institution, give street and number): St. Joseph's Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4009 Essex Road
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Yrs. / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Bernard J. Trainor
16. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Quinn
19a. INFORMANT'S NAME (Type/Print): Charles Albert Cox
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4009 Essex Rd.,Baltimore, Md. 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery 5-18-89
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather / Roy H. Cather
22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck,Inc.5305 Harford Rd.,Balto.,Md.21214

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiorespiratory arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | bronchogenic carcinoma with metastases | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | breast carcinoma | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D-31451
29d. DATE SIGNED (Month, Day, Year): 5/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James J KMETZO
31. DATE FILED (Month, Day, Year): MAY 15 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13115 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Doris Katherine Congleton | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 7 / 89 | 3. TIME OF DEATH: 10:10 PM |
| 4. SOCIAL SECURITY NUMBER: 212-01-8055 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8 - 19-1900 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 7037 Heathfield Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore Co. | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7037 Heathfield Rd. | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): August Plitt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Minerva Plitt | |
| 19a. INFORMANT'S NAME (Type/Print): Eileen M. Sadtler | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7037 Heathfield Rd. Baltimore, Md. 21212 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John D. Reif | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd., Baltimore, Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Multiple system failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) / 26b. TIME OF INJURY / 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen Laiken MD. Stephen LAIKEN | 29c. LICENSE NUMBER: D22517 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 6301 N. Charles St. Balt. 21212 | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13116 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FRANCES Z. CAPOZZI | | | 2. DATE OF DEATH (Month, Day, Year): 05 25 89 | 3. TIME OF DEATH: 8:4]PM M |
| 4. SOCIAL SECURITY NUMBER: 212-18-8406 | 5. SEX: 1 M 2 X F | 6. AGE (In yrs. last birthday): 84 ~~85~~ YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05/29/904 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Balto. | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 6802 Dunhill Rd. | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): John Ziolkowski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Sadowski | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. ~~Marion~~ Marian C. ~~Drach~~ Drach | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 205 E. Joppa Rd. Towson, Md. 21204 Unit #602 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify): Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley 5/30/89 | 20c. LOCATION — City or Town, State: Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald C. Ruck Sr. | 22. NAME AND ADDRESS OF FACILITY: 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. MULTIPLE PULMONARY EMBOLI
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Nicholas P. Georges M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
NICHOLAS P. GEORGES M.D. , G.B.M.C., 670] N.CHARLES ST.,BALTIMORE,MD. 2]204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): JUN 01 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 1316

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13117

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elsie Irene Dennis
2. DATE OF DEATH: MONTH 5 DAY 22 YEAR 89
3. TIME OF DEATH: 7:45 a M
4. SOCIAL SECURITY NUMBER: 212-36-6800
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7 24 02
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Maryland Masonic Homes
9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville
9c. COUNTY OF DEATH: Baltimore Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore County
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7936 Rolling View Rd.
10f. ZIP CODE: 21236
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 years; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Francis J. Orem
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Myers
19a. INFORMANT'S NAME (Type/Print): Maryland Masonic Home
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 International Circle, Cockeysville, Md. 21030
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gar.
20c. LOCATION — City or Town, State: Lutherville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John D. Ruff
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. Baltimore,Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure — Hours

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pulmonary Edema — Yrs.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul M. Rivas
29c. LICENSE NUMBER: D25488
29d. DATE SIGNED (Month, Day, Year): ▶ May 23, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul M. Rivas, M.D. 300 International Circle, Cockeysville, Md. 21030
31. DATE FILED (Month, Day, Year): MAY 24 1989
32. REGISTRAR'S SIGNATURE: Julia Gordon-Rudasill

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13118

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/removal permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Thelma Dolores Dishler
2. DATE OF OEATH — MONTH: May DAY: 9, YEAR: 1989
3. TIME OF OEATH: 830 P M
4. SOCIAL SECURITY NUMBER: 213 30 8951
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 8 1913
8. BIRTHPLACE (State or Foreign Country): Balto., Md.
9a. FACILITY NAME (If not institution, give street and number): 1712 Brown's Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Essex
9c. COUNTY OF OEATH: Baltimore Co.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Essex
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1712 Brown's Rd.
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): George Saddler
18. MOTHER'S NAME (First, Middle, Maiden Surname): Effa Cook
19a. INFORMANT'S NAME (Type/Print): Dorothy L. Samuels, Daughter
19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1712 Brown's Rd. Balto., Md. 21221
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF OISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA, 1407 Old Eastern Ave. Balto., Md. 21221

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac arrest | sudden death |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Hypertensive heart disease | 28 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 5 ☐ Other (Specify)
27. MANNER OF OEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Micelli MD
29c. LICENSE NUMBER: D07417
29d. DATE SIONED (Month, Day, Year): ▶ 5/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): JOSEPH MICELLI, MD. 108 S. TAYLOR AVE. BALTO, MD 21221
31. DATE FILED (Month, Day, Year): MAY 15 1989
32. REGISTRAR'S SIONATURE: Julia Davidson-Rendeen

DHMH-16 Rev 1/89

89 13119

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Carl S. DeFrank | | | 2. DATE OF DEATH (Month, Day, Year): May 8 1989 | 3. TIME OF DEATH: 8:15 PM |
| 4. SOCIAL SECURITY NUMBER: 204-30-8328 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): January 20, 1940 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Saint Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3400 Roselawn Avenue | | 10f. ZIP CODE: 21214 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 Yrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Building Mgr. | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Dominic DeFrank | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cecelia Clark | |
| 19a. INFORMANT'S NAME (Type/Print): Frances E. DeFrank | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3400 Roselawn Avenue Baltimore, Md. 21214 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial 5/12/89 | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Milton J Knight Jr ▶ Milton J. Knight Jr. | | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Road 21214 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Heart Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Metastatic Colon Carcinoma

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ethan Spiegler MD | 29c. LICENSE NUMBER: D34502 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ETHAN SPIEGLER MD ST JOSEPH HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dandon-Randall | |

DHMH-16 Rev 1/89

Item 2 5-30-89 Film G651 W.H.
Per F/H

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13120

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George Patrick Dorbert Jr. | | | | 2. DATE OF DEATH MONTH DAY: May 23, 1989 | 3. TIME OF DEATH: 10:00 PM |
| 4. SOCIAL SECURITY NUMBER: 217267150 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 06/08/29 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Rosedale | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1540 Rosewick Avenue | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintainence | 16b. KIND OF BUSINESS/INDUSTRY: School System | |
| 17. FATHER'S NAME (First, Middle, Last): George P. Dorbert Sr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amanda | |
| 19a. INFORMANT'S NAME (Type/Print): Mary V. Dorbert | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1540 Rosewick Ave. Baltimore, Md. 21237 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY: Cvach Funeral Home Inc 1211 Chesaco Ave. Balto. Md. 21237 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): | Sudden |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. | Metastatic Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): | 1 Yr |
| c. | Carcinoma of Larynx DUE TO (OR AS A CONSEQUENCE OF): | 1 Yr |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell MD | 29c. LICENSE NUMBER: D-9383 | 29d. DATE SIGNED (Month, Day, Year): 5/24/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell MD - 7501 York Rd Towson MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dawson-Rudasill | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 13150

25

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13121

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William Henry DASHNER | | 2. DATE OF DEATH (Month, Day, Year): May 29, 1989 | 3. TIME OF DEATH: 7:23 p M |
| 4. SOCIAL SECURITY NUMBER: 217 05 4588 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): October 13 1915 / 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville 21237 | 9c. COUNTY OF DEATH: Baltimore County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2538 Island View Road | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th Grade; College (1-4 or 5 +): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sheet Metal | 16b. KIND OF BUSINESS/INDUSTRY: Boiler Company | |
| 17. FATHER'S NAME (First, Middle, Last): Henry William Dashner | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Horner | | |
| 19a. INFORMANT'S NAME (Type/Print): Elva Dashner (wife) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2538 Island View Road Baltimore Maryland 21221 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery | 20c. LOCATION — City or Town, State: Baltimore City Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A. 21221, 1407 Old Eastern Ave Baltimore Maryland | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lung Cancer with Metastasis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Lillian M. Tidler MD / Housestaff | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lillian Tidler MD. 9000 Franklin Square Dr. Balto, Md. 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

Thelma Anna Dobry

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13122

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thelma Dobry | | | 2. DATE OF DEATH (Month, Day, Year): 5 28 89 | 3. TIME OF DEATH: 9:30 AM |
| 4. SOCIAL SECURITY NUMBER: 213 28 9179 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5 31 31 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): St Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | | |
|---|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Rosedale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 1107 Rosedale Ave | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Edward Coscia | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma Peselius. | | | |
| 19a. INFORMANT'S NAME (Type/Print): Charles F. Dobry | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1107 Rosedale Ave Rosedale, Md 21237 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn | 20c. LOCATION — City or Town, State: Balto City | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Cench Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 1211 Chesaco Ave Rosedale MD 21237 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIOPULMONARY ARREST | 30 min. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | myocardial Infarction | 1 wk |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James Corrum MD | 34084 | 5-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Corrum St Joseph's Hospital Towson MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13123 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES DIETOR | | | | | 2. DATE OF DEATH: MONTH 4 DAY 25 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 214-20-1032 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-15-20 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 413 Murdock Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore Maryland | | 9c. COUNTY OF DEATH: Baltimore | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 413 Murdock Road | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 yrs. / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Restauranteur | 16b. KIND OF BUSINESS/INDUSTRY: Restaurant | |
| 17. FATHER'S NAME (First, Middle, Last): Nicholas Dietor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louisa Raymonda | |
| 19a. INFORMANT'S NAME (Type/Print): Holly L. Duggan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5928 Falkirk Road Baltimore, Maryland 21239 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory | 20c. LOCATION — City or Town, State: Baltimore Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donna Stephenake | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld 6500 York Road 21212 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Sepsis | 1 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Bowel obstruction | 3 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Juvenile Rheumatoid arthritis | 55 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D22334 | 29d. DATE SIGNED (Month, Day, Year): ▶ 26 April 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph W. Zebley III, M.D., #102, 7801 York Road, Towson, Md. 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 28 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the hospital or attending physician. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13124

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANN DINTZER | | 2. DATE OF DEATH (Month, Day, Year): MAY 18, 1989 | 3. TIME OF DEATH: 7:45 P M |
| 4. SOCIAL SECURITY NUMBER: 112-03-7401 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-25-17 |
| 8. BIRTHPLACE (State or Foreign Country): NEW YORK | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1307 SUDVALE ROAD 21208 | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1307 SUDVALE RD. | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY | 16b. KIND OF BUSINESS/INDUSTRY: MEDICAL | |
| 17. FATHER'S NAME (First, Middle, Last): NATHAN LOBEL | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIAN GREENBERG | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. NADINE MILLS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4247 MARY RIDGE DRIVE RANDALLSTOWN, MD 21133 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK | 20c. LOCATION — City or Town, State: RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Burton H Levinson | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Carcinoma Breast | 15mos |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: Diabetes; Ischemic Heart Disease

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) home | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: B K [illegible] | 29c. LICENSE NUMBER: D9261 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BRIAN KAHNTROFF 131 Slade Ave 21208 | | |
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] Davidson-Andrews | |

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13125

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THERESA E. DUBNER | | | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 23 / 89 | 3. TIME OF DEATH: 2:30 p M | |
| 4. SOCIAL SECURITY NUMBER: 218-42-4857 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 94 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07/04/1894 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number): SUMMIT NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | | 9c. COUNTY OF DEATH: BALTIMORE | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | | |
| 10e. STREET AND NUMBER: 222 GRALAN ROAD | | 10f. ZIP CODE: 21228 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | | | | | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES J. BLUMENAUER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): THERESA HUBERT | | | | | |
| 19a. INFORMANT'S NAME (Type/Print): H. EARL GANNON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 222 GRALAN ROAD CATONSVILLE, MD 21228 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK MAUSOLEUM | | | 20c. LOCATION — City or Town, State: WOODLAWN, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell C Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD 21228 | | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio pulmonary Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cerebral vascular accident
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ed Thaczuk | D 34951 | ▶ 5/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. ED THACZUK 3350 WILKENS AVENUE SUITE 308 BALTIMORE, MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | Julia Dixon-Landers |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13126
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDWARD EUGENE DAMAST | | | | 2. DATE OF DEATH: MONTH 5 DAY 12 YEAR 89 | 3. TIME OF DEATH: 11:15A M |
| 4. SOCIAL SECURITY NUMBER: 213-07-5437 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/25/08 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 1701 Willis Drive | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Relay | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Relay | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1701 Willis Drive | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Welder | 16b. KIND OF BUSINESS/INDUSTRY: Calvert | |
| 17. FATHER'S NAME (First, Middle, Last): Frederick Wm. Damast | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Madalene Cook | |
| 19a. INFORMANT'S NAME (Type/Print): Audrey Gill | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1701 Willis Drive Relay, Maryland 21227 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie D. Shannon | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ARTERIOSCLEROTIC CARDIOVASCULAR | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DISEASE WITH ARRHYTHMIAS | >10yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE
HYPOTHYROIDISM

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jay Gerstenblith, MD. | 29c. LICENSE NUMBER: D 20724 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gerstenblith St. Agnes Med. Center 3455 Wilkens Ave. | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 13127

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY DAVIS | | | 2. DATE OF DEATH (Month, Day, Year): MAY 30, 1989 | 3. TIME OF DEATH: 8:30 p M |
| 4. SOCIAL SECURITY NUMBER: 216-07-0062 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-14-06 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): MERIDAN MUTTI MED CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 903 E. 37th St. | | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Editor | 16b. KIND OF BUSINESS/INDUSTRY: Medical Journal | |
| 17. FATHER'S NAME (First, Middle, Last): William Strasinger | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Reely | |
| 19a. INFORMANT'S NAME (Type/Print): Mildred S. Moore | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711 Fairway Dr., Towson, Md. 21204 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | 20c. LOCATION — City or Town, State: Parkville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John A Slade | | 22. NAME AND ADDRESS OF FACILITY: 4905 York Rd. Henry W. Jenkins & Sons, Balto., Md.. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of the Lung (Small cell) | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cigarette Smoking up to 2 years before death

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Cerdhony G Lewandowski MD | 29c. LICENSE NUMBER: D 06261 | 29d. DATE SIGNED (Month, Day, Year): ▶ 05-31-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANTHONY A. LEWANDOWSKI, MD 120 SISTER PIERRE DRIVE SUITE 207 TOWSON MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsey | |

OHMN-16 Rev 1/89

88 13151

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13128

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BLANCHE E. ENGLE | | | 2. DATE OF DEATH (Month, Day, Year): 5 3 89 | 3. TIME OF DEATH: 9:00 P M |
| 4. SOCIAL SECURITY NUMBER: 217-34-8962 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-1-05 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Manor Care Nursing Home-Rossville | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore County | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 9619 Pulaski Highway | | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Pueno Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking | |
| 17. FATHER'S NAME (First, Middle, Last): George Albert Edwards | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. George E. Engle | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9619 Pulaski Highway Balto., Md. 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Balto., Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lasasso Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reapiretory arrest, shock, or haert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Ischemic heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cerebal Vascular Disease
Diabetes

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Howard I Bond | 29c. LICENSE NUMBER: D14793 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 9618 Belair Rd Baltimore Md 21236

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 13129

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

1071

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles E. Estes | | | | 2. DATE OF DEATH (Month, Day, Year): May 8, 89 | 3. TIME OF DEATH: 9:15 P M |
| 4. SOCIAL SECURITY NUMBER: 409-26-5606 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 9, 1924 | 8. BIRTHPLACE (State or Foreign Country): Tennessee |
| 9a. FACILITY NAME (If not institution, give street and number): 5405 Hutton Avenue 21207 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Woodlawn | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Woodlawn | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 5405 Hutton Avenue | | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1941 - 1944 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clergy-Visiting Pastor | | 16b. KIND OF BUSINESS/INDUSTRY: Liberty Reformed Presbyt.Ch | |
| 17. FATHER'S NAME (First, Middle, Last): Claude Selmer Estes | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mamie Bell Haynes | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Frances Estes | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5405 Hutton Avenue Baltimore, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery 5/11/89 | | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen M. Sanders | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): and Congestive Heart failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: DO4299 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/9/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13130
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SARAH E. ENGELS | | | | 2. DATE OF DEATH (Month, Day, Year): May 17, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215-12-0352 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 100 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 15, 1888 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Cockeysville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 18 Beehive Place, Apt. H | | 10f. ZIP CODE: 21030 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): William Maguire | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Hartman | |
| 19a. INFORMANT'S NAME (Type/Print): Mildred E. Gill | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery 5/20/89 | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald E. Schuyler Sr. | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASCVD | 5+ yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell | 29c. LICENSE NUMBER: D-9283 | 29d. DATE SIGNED (Month, Day, Year): 20 May 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell, M.D. - 7501 York Rd. - Towson, Md. 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landau |

DHMH-16 Rev 1/89

98 13130

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13131 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial-transit permit.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|
| HENRY L. EDMONDS | | 05 / 22 / 89 | 7:05 p M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 414-28-3357 | 1 [X] M 2 [ ] F | 68 YRS. | | | 08-22-20 | TENNESSEE |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| VA MEDICAL CENTER | FT. HOWARD | BALTIMORE CO |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | | BALTIMORE | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 500 N. MONTFORD AVENUE | 21205 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [X] YES 2 [ ] NO — WW II | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th | | | US NAVY |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JAMES EDMONDS | LIZA RITTER |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CLINICAL RECORDS | VA MEDICAL CENTER FT HOWARD, MARYLAND 21052 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Cedar Hill | Baltimore, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] | Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. BILATERIAL PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OLD RIGHT CVA

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | | 5-24-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

C.V.J. VERGHESE, M.D. VA MEDICAL CENTER FORT HOWARD, MD 21052

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13132
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALICE B. EISER | | | 2. DATE OF DEATH (Month, Day, Year): 5-25-89 | 3. TIME OF DEATH: 1055 M |
| 4. SOCIAL SECURITY NUMBER: 212-28-7644 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/29/04 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): Balto. Co. General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Randallstown | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Old Court Nursing Home 5412 Old Court Rd. | | 10f. ZIP CODE: 21133 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cafeteria Worker | 16b. KIND OF BUSINESS/INDUSTRY: Dept. Of Education | |
| 17. FATHER'S NAME (First, Middle, Last): Philip Webler | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Harriett Alice McGraw | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Eileen Lance | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7030 Deerfield Road Pikesville, MD 21208 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John L. Hemler | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | 0 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DILATED CARDIOMYOPATHY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD, SEIZURE DISORDER, DM

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD | 29c. LICENSE NUMBER: D37333 | 29d. DATE SIGNED (Month, Day, Year): 5-25-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C-RAVI MD, BCGH, RANDALLSTOWN, MD | | |
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13133

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELEANOR E. EVOY | | 2. DATE OF DEATH: MONTH 5 DAY 25 YEAR 89 | 3. TIME OF DEATH: 7:00 P.M. |
| 4. SOCIAL SECURITY NUMBER: 212 32 2353 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1/8/02 |
| 8. BIRTHPLACE (State or Foreign Country): MD | | | |
| 9a. FACILITY NAME (If not institution, give street and number): College Manor Nursing Home | 9b. CITY, TOWN OR LOCATION OF DEATH: Lutherville | 9c. COUNTY OF DEATH: Balimore | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3925 Beech Ave. | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrator | 16b. KIND OF BUSINESS/INDUSTRY: Family &Children's Soc. |
| 17. FATHER'S NAME (First, Middle, Last): Joseph T. Evoy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Herman | |
| 19a. INFORMANT'S NAME (Type/Print): Mary E. Barnes | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3520 Lyndale Ave., Balto., MD 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Balto., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R.D. Ritter | | 22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins & Sons Co. 4905 York Rd., Balto., MD 21212 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Upper Respiratory Infection | 2 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Advanced Age
COPD

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E. Souweine MD | 29c. LICENSE NUMBER: D 24732 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. Timothy Souweine, MD. 1134 York Road, Lutherville 21093

31. DATE FILED (Month, Day, Year): MAY 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13134
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dora E. Ellsworth
2. DATE OF DEATH (Month, Day, Year): May 25, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 184 14 3160D
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan 29 1898
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 3615 Glenwood Road
9b. CITY, TOWN OR LOCATION OF DEATH: Middle River
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Middle River
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 3615 Glenwood Road
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): ? — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Henry Burkhardt
18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Strock
19a. INFORMANT'S NAME (Type/Print): Margaret D. Biddison, Daughter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3615 Glenwood Rd. Balto. Md. 21220
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): L. M. Frye Funeral Home
20c. LOCATION — City or Town, State: Monongahela, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA, 1407 Old Eastern Ave. Balto. Md. 21221

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. M.I.
DUE TO (OR AS A CONSEQUENCE OF): ASCVD
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF): Fract hip
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D09631
29d. DATE SIGNED (Month, Day, Year): 5-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 805 Fieldcrest Avenue Balto md 21220 Marvin J. Rombro MD
31. DATE FILED (Month, Day, Year): MAY 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13135
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JANET FORMICA
2. DATE OF DEATH (Month, Day, Year): 5 - 18 - 89
3. TIME OF DEATH: 4:00 P.M.
4. SOCIAL SECURITY NUMBER: 216-16-4688
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/10/05
8. BIRTHPLACE (State or Foreign Country): ITALY
9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH'S HOSPITAL Towson
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, MD
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Balto
10c. CITY, TOWN OR LOCATION: MILLERS, Md
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3705 ROCKDALE ROAD
10f. ZIP CODE: 21107
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th
College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): seamstress
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Antonio Masanielo
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annadonia Varella
19a. INFORMANT'S NAME (Type/Print): Mary Ann Shiels
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3405 Rockdale Rd, Millers, Md. 21107
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph N. Zannino Jr.
22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Funeral Home
263 S. Conkling Street, 21224

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute myocardial infarction | 1-3 days approximately |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Diabetes mellitus | 2 years |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Urinary tract infection

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Natividad D. de Leon M.D.
29c. LICENSE NUMBER: D19508
29d. DATE SIGNED (Month, Day, Year): 5-18-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NATIVIDAD D. DE LEON, M.D. C/O ST. JOSEPH HOSPITAL, TOWSON, MD 21204
31. DATE FILED (Month, Day, Year): MAY
32. REGISTRAR'S SIGNATURE

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88 13132

89 13136

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Georgianna Catherine Fickus | | 2. DATE OF DEATH (Month, Day, Year): May 16, 1989 | 3. TIME OF DEATH: 1:30 P M |
| 4. SOCIAL SECURITY NUMBER: 214 05 3585 | 5. SEX: 1 ☐ M 2 ☒ | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): May 13, 1905 | 8. BIRTHPLACE (State or Foreign Country): Maryland | | |

~~Georgianna~~ ~~FICKUS~~

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville 21237 | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 13223 Rivervan Ave. | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO; IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress | 16b. KIND OF BUSINESS/INDUSTRY: Clothing | |
| 17. FATHER'S NAME (First, Middle, Last): Edward Young | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna C. Reichert | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert J. Fickus, Jr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13223 Rivervan Ave. Balto. Md. 21220 | | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Severe Aspiration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia of Right Lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul A Walk MD | 29c. LICENSE NUMBER: D26835 | 29d. DATE SIGNED (Month, Day, Year) ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 13130

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13137 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): AGNES ROBERTA FALATICO (Agnes Falatico) | | | 2. DATE OF DEATH: MONTH 5 DAY 20 YEAR 89 | | 3. TIME OF DEATH: 5:25 AM |
| 4. SOCIAL SECURITY NUMBER: 212-03-3867D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-17-16 | | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL (St. Joseph Hospital) | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON (Towson) | | 9c. COUNTY OF DEATH: BALTIMORE (Baltimore County) | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 50 Murdock Road | | 10f. ZIP CODE: 21212 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY: Self Emp. | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Hlobick | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Karatva | | | |
| 19a. INFORMANT'S NAME (Type/Print): Michael D. Falatico | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 50 Murdock Road Baltimore, Md. 21212 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Trinity Russian Orthodox Cem. | | 20c. LOCATION — City or Town, State: Elkridge Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Xenakis (Dennis Stephen Xenakis) | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. 21212 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Severe Congestive Heart Failure — 6 months
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| N/A | M | 1 ☐ YES 2 ☐ NO | N/A |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Duane Smoot D | D31831 | ▶ 5/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Duane Smoot 7620 York Road Towson, Md. 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | Julia Davidson-Landrum |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13138
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): HARRY FINE (HARRY FINE)
2. DATE OF DEATH (Month, Day, Year): 5-14-89
3. TIME OF DEATH: 645 P M
4. SOCIAL SECURITY NUMBER: 218-14-2270
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-29-05
8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hos.
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown Md
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6952 Millbrook Park APT. 14
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [XX] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN
16b. KIND OF BUSINESS/INDUSTRY: RETAIL
17. FATHER'S NAME (First, Middle, Last): CHARLES FINE
18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE SWARTZ
19a. INFORMANT'S NAME (Type/Print): FRED BERGERSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6526 SOUTH FRIENDS AVE. WHITTIER, CA 90607
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HAR ZION TIFEREETH ISRAEL
20c. LOCATION — City or Town, State: ROSEDALE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sie Kien Ong M.D., House Physician
29c. LICENSE NUMBER: D36456
29d. DATE SIGNED (Month, Day, Year): 5/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sie Kien Ong M.D. Baltimore County General Hospital, Randallstown, MD 21133
31. DATE FILED (Month, Day, Year): 5/MAY/89 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau

DHMH-1 Rev 1/89

88 13138

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13139
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARVEY FINK HARVEY Vincent Fink
2. DATE OF DEATH (Month, Day, Year): 5 / 27 / 89
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 213-05-5518
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-14-11
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): RIVERVIEW NURSING CENTRE, INC
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO, MD (ESSEX)
9c. COUNTY OF DEATH: BALTO

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Dundalk
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 704 Gregwood Court
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. 2
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chauffeur
16b. KIND OF BUSINESS/INDUSTRY: Trucking
17. FATHER'S NAME (First, Middle, Last): Andrew Fink
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Neinlein
19a. INFORMANT'S NAME (Type/Print): Joyce Rossi
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 704 Gregwood Court Dundalk, Md. 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery
20c. LOCATION — City or Town, State: Eastwood, Balto. Co., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles S. Zeiler
22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 901 S. Conkling St.
Charles S. Zeiler

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | obstructive jaundice | 1-2wks. |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Carcinoma, probably pancreas. | months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: PHYSICIAN
29c. LICENSE NUMBER: D29601
29d. DATE SIGNED (Month, Day, Year): ▶ 5/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH B. ILLIGMAN, M.D. 5901 HARFORD RD. BALT. MD. 21214
31. DATE FILED (Month, Day, Year): MAY 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13140
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Florence R Forsythe | | | | 2. DATE OF DEATH (Month, Day, Year): May 13, 1989 | 3. TIME OF DEATH: 6:00A M |
| 4. SOCIAL SECURITY NUMBER: 218-03-6802 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 05/04/04 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 1227 Pleasant Valley Road | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Operator | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Ernest Granville Rea | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Blanche Edwards | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. George E. Forsythe | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1227 Pleasant Valley Road, Catonsville, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery | | 20c. LOCATION — City or Town, State: Woodlawn, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Md. 21227 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Urinary Tract Infection | 5days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Alzheimer's Disease | 10yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Bullus Pemphigoid

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| David A. Moseman MD | D19871 | ▶ 5-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Moseman, M.D. Arbutus, Md. 21227

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | Julia Davidson-Lindsay |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13141 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): KARL GEORGE FRIEDEL

**2. DATE OF DEATH** Month: 5 Day: 3 Year: 89

**3. TIME OF DEATH**: 10:47 PM

**4. SOCIAL SECURITY NUMBER**:

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 73 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 3/10/14

**8. BIRTHPLACE** (State or Foreign Country): MD.

**9a. FACILITY NAME** (If not institution, give street and number): BALTIMORE CO. GEN. HOSP

**9b. CITY, TOWN OR LOCATION OF DEATH**: RANDALLSTOWN

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: CARROLL

**10c. CITY, TOWN OR LOCATION**: SYKESVILLE

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 6207 WALNUT AVE

**10f. ZIP CODE**: 21784

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 7 GRADE
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): EQUIPMENT OPERATOR

**16b. KIND OF BUSINESS/INDUSTRY**: BALTO CITY

**17. FATHER'S NAME** (First, Middle, Last): GEORGE FRIEDEL

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): ANNE WITHOFF

**19a. INFORMANT'S NAME** (Type/Print): HAZEL BELLE FRIEDEL

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6207 WALNUT AVE SYKESVILLE MD 21784

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): LAKE VIEW MEMORIAL PARK

**20c. LOCATION — City or Town, State**: SYKESVILLE, MD. 21784

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Harry W. Haight

**22. NAME AND ADDRESS OF FACILITY**: HAIGHT FUNERAL HOME BOX 195 SYKESVILLE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pulmonary Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Edmund P. Tkaczuk MD

**29c. LICENSE NUMBER**: D34957

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5/3/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): EDMUND P. TKACZUK

**31. DATE FILED** (Month, Day, Year): MAY 4 1989

**32. REGISTRAR'S SIGNATURE**

DHMH-16 Rev 1/89

89 13141

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13142
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH B. FLATTERY | | | | | 2. DATE OF DEATH (Month, Day, Year): May 1, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 059-07-5976 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan. 12, 1903 | 8. BIRTHPLACE (State or Foreign Country): Missouri |
| 9a. FACILITY NAME (If not institution, give street and number): 1021 W. Seminary Avenue | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lutherville | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Lutherville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1021 W. Seminary Ave. | | 10f. ZIP CODE: 21093 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper | 16b. KIND OF BUSINESS/INDUSTRY: Accounting |
| 17. FATHER'S NAME (First, Middle, Last): James B. Brown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Adele M. Meyers | |
| 19a. INFORMANT'S NAME (Type/Print): James W. Flattery - | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem.Gdns.5/3/89 | 20c. LOCATION — City or Town, State: Timonium, Md. 21093 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Earl L. Cargo Jr. | | 22. NAME AND ADDRESS OF FACILITY: 1050 York Road Ruck Towson Funeral Home, Inc., Towson, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease — 4 yrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Stoner MD | 29c. LICENSE NUMBER: D13272 | 29d. DATE SIGNED (Month, Day, Year): ▶5-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert E. Stoner, MD Suite 506 120 Sister Pierre Dr. Towson MD. 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 3 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Spindler |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13143

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gladys P. FROCK | | | 2. DATE OF DEATH (Month, Day, Year): May 10, 1989 | 3. TIME OF DEATH: 10:05 AM |
| 4. SOCIAL SECURITY NUMBER: 214-03-6523-D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): July 17 1904 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore Co. |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: ---- | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5701 Arnhem Rd. | | 10f. ZIP CODE: 21206 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Jacob Bubb | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Houseman | | |
| 19a. INFORMANT'S NAME (Type/Print): Paul L. Frock Sr. (son) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5701 Arnhem Rd., Baltimore, Md. 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Lorraine Park | | 20c. LOCATION — City or Town, State: Baltimore Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral HOme Inc. 3331 Brehms Lane, Balto. Md. 21213 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Dysrhythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Dilated Caridomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypertension | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| HAMMETT MD | | ▶ May 10, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carolyn Hammett, M.D. 9000 Franklin Sq. Dr, 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

89 13144

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ella M. Foster | | | 2. DATE OF DEATH Month: 5/11 Day: 89 Year: 89 | 3. TIME OF DEATH: 7:04 M |
| 4. SOCIAL SECURITY NUMBER: 220-07-2592 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8-25-89 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3725 W. Coldspring Lane | 10f. ZIP CODE: | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES: xx | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Lee Allen | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Brown | |
| 19a. INFORMANT'S NAME (Type/Print): Blanche Walker | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3554 Carraige Hill Circle #104 Randallstown, Maryland | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other): Maryland National Mem. Park | 20c. LOCATION — City or Town, State: Laurel, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jerry Harris | 22. NAME AND ADDRESS OF FACILITY: Chatman-Harris Funeral Home 1701 McCulloh Street Balto, Md 21217 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebro/vascular accident | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Edmund P. Tkacz MD | 29c. LICENSE NUMBER: D34957 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Balt. County General Hospital, EDMUND P. TKACZ MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13145
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Jerome I. Feld

**2. DATE OF DEATH** MONTH 5 DAY 20 YEAR 89

**3. TIME OF DEATH**: 7:45 PM

**4. SOCIAL SECURITY NUMBER**: 214-03-1558

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 70 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 11-19-18

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): Stella Maris Hospice Unit

**9b. CITY, TOWN OR LOCATION OF DEATH**: Towson, Md.

**9c. COUNTY OF DEATH**: Baltimore County

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**: PIKESVILLE

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 3203 OLD POST DR. APT. 9

**10f. ZIP CODE**: 21208

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW II ARMY

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th GRADE
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): TAILOR

**16b. KIND OF BUSINESS/INDUSTRY**: MENS CLOTHING

**17. FATHER'S NAME** (First, Middle, Last): LOUIS FELD

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): ANNA SMITH

**19a. INFORMANT'S NAME** (Type/Print): MRS. REBECCA FELD

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3203 OLD POST DR. APT. 9, Balto., Md. (21208)

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): HEBREW YOUNG MENS CEM.

**20c. LOCATION — City or Town, State**: WOODLAWN, MD.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Burton H. Levinson

**22. NAME AND ADDRESS OF FACILITY**: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hepatoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEDUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] ND

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**

**29c. LICENSE NUMBER**: 15504

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5-20-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Eddie Nakhuda M.D. 2300 Dulaney Valley Rd. Towson Md. 21204

**31. DATE FILED** (Month, Day, Year): MAY 24 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

Charles Albert Forster

89 13146

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles FORSTER | | 2. DATE OF DEATH (Month, Day, Year): May 14, 1989 | 3. TIME OF DEATH: 8:05 pM |
| 4. SOCIAL SECURITY NUMBER: 216 05 5655 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5/11/15 |
| 8. BIRTHPLACE (State or Foreign Country): Md | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Balto | 10c. CITY, TOWN OR LOCATION: Rosedale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2009 Summit Ave | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Service Station | 16b. KIND OF BUSINESS/INDUSTRY: Self Employed. |
| 17. FATHER'S NAME (First, Middle, Last): Charles Albert Forster | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Belle Lewis | |
| 19a. INFORMANT'S NAME (Type/Print): Vivian K Forster | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2009 Summit Ave Rosedale Md 21237 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: Rossville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: 1211 Chesico Ave Rosedale Funeral Home | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. POSSIBLE ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ASCVD

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — (At home) farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D-14221 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5.15.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 223 E. Belvd Balto Md 21221 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 MAY 16 89 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13147

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

K

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Emma Marie Freeman | | | 2. DATE OF DEATH (Month, Day, Year): 5 28 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218-03-5799 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6 28 07 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 32 Edmondson Ridge Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 32 Edmondson Ridge | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY? United States |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 years; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Howard Eckman | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Emma Lillie Hammack | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32 Edmondson Ridge Road Catonsville, MD 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | | 20c. LOCATION — City or Town, State: Woodlawn, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen M. Jenkins | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adenocarcinoma Bile Duct. — 17 mos.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ____ DUE TO (OR AS A CONSEQUENCE OF):

c. ____ DUE TO (OR AS A CONSEQUENCE OF):

d. ____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Glen E Johnson MD | D 19558 | ▶ 5/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Glen E Johnson MD Suite 202 Pine Heights Medical Center, 1001 Pine Heights Ave Balt. Md 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| JUN 01 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

ITEM #7&10b FILM #G652 PER: F. H. 6/22/89 J. A.

Item# 7 per FH film 653 7/5/89fj

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13148 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DELORES SARAH FITCHETT | | | | 2. DATE OF DEATH (Month, Day, Year): 5 21 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218-28-6482 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2 04 1933 | BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 3701 LIBERTY HEIGHTS AVENUE B-3 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ~~BALTIMORE~~ | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3701 LIBERTY HEIGHTS AVENUE | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 56- 59 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK | 16b. KIND OF BUSINESS/INDUSTRY: U. S. POSTAL SERVICE | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN S. FITCHETT | 18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA HALL | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. SHIRLEY M. BRAWNER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4544 THE STRAND BALTIMORE, MARYLAND 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, CO., MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R. Ensey Jr. | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC BREAST CA. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stan H. Glaser | 29c. LICENSE NUMBER: 8-20472. | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/23/89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANTON H. GLASER 1777 REISTERSTOWN RD- PIKESVILLE, MD. 21208 | | |
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13149 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lucille Marie GREEN / Lucille M. Green | | | 2. DATE OF DEATH: MONTH 05 DAY 29 YEAR 89 | 3. TIME OF DEATH: 1:25 P M |
| 4. SOCIAL SECURITY NUMBER: 219-01-4504 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): XX 92 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-16-1896 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Balto. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: BALTO | 10c. CITY, TOWN OR LOCATION: BALTO. Perry Hall, | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 9018 Belair Rd. | 10f. ZIP CODE: 21236 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home maker | 16b. KIND OF BUSINESS/INDUSTRY: ---------- | |
| 17. FATHER'S NAME (First, Middle, Last): John Jones | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Louise Fields | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Jackie Hacke | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 E. Joppa Road Baltimore, MD 21236 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Joseph's Cemetery | 20c. LOCATION — City or Town, State: Fullerton, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin J. Dippel Jr. | | 22. NAME AND ADDRESS OF FACILITY: Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD 21206 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or hasrt failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. GASTROENTESTINAL BLEED

DUE TO (OR AS A CONSEQUENCE OF):

c. INFECTED DECUBITI

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying csuse given in Part I. NONE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Shirley Thompson | 29c. LICENSE NUMBER: D33215 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Shirley Thompson, M.D. St. Joseph Hospital Towson, MD. | | |
| 31. DATE FILED (Month, Day, Year): MAY 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 13150

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCES A. GIGLIOTTI
2. DATE OF DEATH (Month, Day, Year): 5 23 89
3. TIME OF DEATH: 9:44 A M
4. SOCIAL SECURITY NUMBER: 217-09-9465
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-06-18
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. MD 21204
9c. COUNTY OF DEATH: Balto.

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Balto.
10c. CITY, TOWN OR LOCATION: Towson, Md.
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1032 Winsford Rd
10f. ZIP CODE: Balto, MD 21204
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: School
17. FATHER'S NAME (First, Middle, Last): Frank Vitale
18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Cammarata
19a. INFORMANT'S NAME (Type/Print): Mr. Chester Gigliotti
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1032 Winsford Rd. 21204
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery 5/24/89
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald C. Schaefer Sr.
22. NAME AND ADDRESS OF FACILITY: 1050 York Rd. 21204 — Ruck Towson Funeral Home, Inc.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Biliary tract carcinoma with liver metastases — 4 yrs.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Natividad D. de Leon M.D.
29c. LICENSE NUMBER: D 19508
29d. DATE SIGNED (Month, Day, Year): 5/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NATIVIDAD D. DE LEON, C/O ST. JOSEPH HOSPITAL, TOWSON, MD. 21204
31. DATE FILED (Month, Day, Year): MAY 25 1989
32. REGISTRAR'S SIGNATURE: Julia Dorsey Riddick

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13151
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ruth Anne GEORGE | | | | | 2. DATE OF DEATH (Month, Day, Year): May 10, 1989 | | 3. TIME OF DEATH: 10:30 A M |
| 4. SOCIAL SECURITY NUMBER: 213-30-9842A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/22/32 | | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH: Baltimore | | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE | | 10c. CITY, TOWN OR LOCATION | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO | | |
| 10e. STREET AND NUMBER: 5220 YORK ROAD-APT. 3-O | | | 10f. ZIP CODE: 21212 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): RAMON H. GEORGE | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA D. SMITH | | | | |
| 19a. INFORMANT'S NAME (Type/Print): FRANKLIN HART JR. | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4726 Meise Dr., Baltimore, Md. 21206 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | | 20c. LOCATION — City or Town, State | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald Wheeler | | | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Severe Bradycardia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Alfred Covington MD | N/A | ▶ May 10, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alfred Covington M.D. 9000 Franklin Sq. Dr., 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 24 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 1315

89 13152

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anne Q. Gordon | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 05 / 89 | 3. TIME OF DEATH: 12:40 aM |
| 4. SOCIAL SECURITY NUMBER: 705-09-8137 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 06/28/1896 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7600 Clays Lane | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: own home | |
| 17. FATHER'S NAME (First, Middle, Last): Allen B. Quinian | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fanny H. Sewall | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth Deane | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6003 Lakehurst Drive 21210 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park | 20c. LOCATION — City or Town, State: Balto, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter D. Ashton Mccall | | 22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Estate, P.A. 736 Edmondson Avenue 21228 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebral Anoxia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Urosepsis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rezazadeh MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hamied Rezazadeh, M.D. G.B.M.C.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Gardner |

DHMH-16 Rev 1/89

88 13125

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13153
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy L. Goodman
2. DATE OF DEATH — MONTH: May; DAY: 21; YEAR: 1989
3. TIME OF DEATH: 3:45 PM
4. SOCIAL SECURITY NUMBER: 214-24-7437
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 62 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-10-27
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 213 Homevale Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Reisterstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 213 Homevale Road
10f. ZIP CODE: 21136
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Sebastian Zito
18. MOTHER'S NAME (First, Middle, Maiden Surname): Conradena Pressprich
19a. INFORMANT'S NAME (Type/Print): Lewis L. Goodman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Hillside Ave. Cockeysville, Md. 21030
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery
20c. LOCATION — City or Town, State: Pikesville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Brian Powell
22. NAME AND ADDRESS OF FACILITY: Eline Funeral Home Reisterstown, Md

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Breast Cancer — 18 mos
DUE TO (OR AS A CONSEQUENCE OF):
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James A. Quinlan
29c. LICENSE NUMBER: D-12590
29d. DATE SIGNED (Month, Day, Year): ▶ 5/2-/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Quinlan, M.D. 11904 Reisterstown Rd. 21136
31. DATE FILED (Month, Day, Year): MAY 26 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill

DHMH-16 Rev 1/89

88 13123

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13154
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): STERLING A GLENN | | | | 2. DATE OF DEATH (Month, Day, Year): 05 03 89 | 3. TIME OF DEATH: 7:59 PM |
| 4. SOCIAL SECURITY NUMBER: 578-03-5479 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 02-07-14 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTO. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE CO | 10c. CITY, TOWN OR LOCATION: BALTO | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2842 CUB HILL RD | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SYSTEMS ANAL. | 16b. KIND OF BUSINESS/INDUSTRY: BENDIX | |
| 17. FATHER'S NAME (First, Middle, Last): RUSSELL S. GLEEN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CLAUDIA A. HAAR | |
| 19a. INFORMANT'S NAME (Type/Print): GLENN, DAVID | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10013 HARFORD RD BALTO MD 21234 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREENMOUNT CEM. | 20c. LOCATION — City or Town, State: BALTO. CITY. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter J. Gair | | 22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL 8800 HARFORD RD. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARCINOMA BRONCHUS / CONGESTIVE CHF. ARTH. DIS. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PNEUMONIA | 1 DAY |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(2) VENTRICULAR TACHYARRHYTHMIAS
ATHEROSCLEROTIC ANEURYSM, CORONARY
S/P MYOCARDIAL INFARCTIONS X 3

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles F. Moore, MD | D 20390 | ▶ 5/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 11 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13155 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIA GRAZIANO | | | | 2. DATE OF DEATH (Month, Day, Year): May 10, 1989 | 3. TIME OF DEATH: 7:46 AM |
| 4. SOCIAL SECURITY NUMBER: 219-58-1134 | 5. SEX: 1 ☐ M 2 ☒ F XX | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan. 26, 1896 | 8. BIRTHPLACE (State or Foreign Country): Italy |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hosp. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Ransallstown | | 9c. COUNTY OF DEATH: Baltimore County |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1301 Ablett Road | | 10f. ZIP CODE: 21239 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed XX 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO XX IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO X Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): None; College (1-4 or 8+): None | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Agostino Glorioso | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Concetta Cimino | |
| 19a. INFORMANT'S NAME (Type/Print): Laura C. Portera | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1301 Ablett Road Baltimore, Maryland 21239 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State: Howard Co., Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ISCHEMIC CARDIOMYOPATHY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | 0' min |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE, SEVERE ANEMIA, RENAL FAILURE

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD | 29c. LICENSE NUMBER: D37333 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-10-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI, BCGH, RANDALLSTOWN, MD. | | |
| 31. DATE FILED (Month, Day, Year): MAY 11 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Landwehr | |

DHMH-18 Rev 1/89

3

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13156

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): ANGELA I. GOLDEN | | | 2. DATE OF DEATH (Month, Day, Year): 05/06/89 | 3. TIME OF DEATH: 8 P. M |
| 4. SOCIAL SECURITY NUMBER: 325-16-7969 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 31 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08/07/07 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): BALTO.CO.GEN.HOSPT. | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: REISTERSTOWN | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 207 ERIN WAY | | 10f. ZIP CODE: 21136 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 College | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Orlando Harwood | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA Kelly | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs.Julia F. Wheeler | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Norris Run Court Reisterstown Md 21136 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JERUSALEM CEMETERY | 20c. LOCATION — City or Town, State: BARBOUR CO., W.VA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank E. Cline | | 22. NAME AND ADDRESS OF FACILITY: CLINE FUNERAL HOME, REISTERSTOWN, MD. 21136 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myelocytic leukemia 6 wks | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pelvic mass

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D | 29c. LICENSE NUMBER: D16467 | 29d. DATE SIGNED (Month, Day, Year): 5-8-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSE APTED, M.D 100 OWINGS CT - REISTERSTOWN

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 9 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13157
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): HAROLD WILLIAM GOOD

**2. DATE OF DEATH** (Month, Day, Year): 5 4 1989

**3. TIME OF DEATH**: 6:10 A. M

**4. SOCIAL SECURITY NUMBER**: 719-03-1627

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 70 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 10/23/18

**8. BIRTHPLACE** (State or Foreign Country): MARYLAND

**9a. FACILITY NAME** (If not institution, give street and number): INNS OF EVERGREEN WEST

**9b. CITY, TOWN OR LOCATION OF DEATH**: CATONSVILLE

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**: CATONSVILLE

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 919 MARKSWORTH RD.

**10f. ZIP CODE**: 21228

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): RAILROAD ENGINEER

**16b. KIND OF BUSINESS/INDUSTRY**: B&O RAILROAD

**17. FATHER'S NAME** (First, Middle, Last): WILLIAM F. GOOD

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): MARY G. NUSE

**19a. INFORMANT'S NAME** (Type/Print): NELLIE JANICE GOOD

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 919 MARKSWORTH RD. CATONSVILLE, MD. 21228

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): PARK HEIGHTS CEMETERY

**20c. LOCATION — City or Town, State**: FREDERICK, MD.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Russell Witzke

**22. NAME AND ADDRESS OF FACILITY**: 1630 EDMONDSON AVE. CATONSVILLE, MD. 21228
LEROY M. & RUSSELL C. WITZKE FUNERAL HOME

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ASVD
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [✓] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Marc Damm

**29c. LICENSE NUMBER**: D23760

**29d. DATE SIGNED** (Month, Day, Year): 5/4/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): DR. MARK DAVIS 9141 BALTIMORE NATIONAL PIKE BALTIMORE, MD. 21043

**31. DATE FILED** (Month, Day, Year): MAY 8 - 1989

**32. REGISTRAR'S SIGNATURE**: Gisha Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13158
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George GOETZ | | | | 2. DATE OF DEATH (Month, Day, Year): May 7 1989 | 3. TIME OF DEATH: 5:58 p M |
| 4. SOCIAL SECURITY NUMBER: 219-07-9767 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5/24/15 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md. | | 9c. COUNTY OF DEATH: Baltimore County |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Cecil | 10c. CITY, TOWN OR LOCATION: Port Deposit | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 39 York Drive | | 10f. ZIP CODE: 21904 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: X | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dry Cleaners | 16b. KIND OF BUSINESS/INDUSTRY: Aberdeen Cleaners | | | |
| 17. FATHER'S NAME (First, Middle, Last): Gottleib Goetz | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Carolyn Traub | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Irma T. Goetz | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 39 York Drive, Port Deposit, Md. 21904 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | | 20c. LOCATION — City or Town, State: Bel Air, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Tarring | | 22. NAME AND ADDRESS OF FACILITY: Tarring Funeral Home, P.A. Aberdeen, Marylnad 21001-3399 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Electromechanical Dissociation

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul Hagan | D37242 | ▶ 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Hagan 9000 Franklin Square Drive Baltimore 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 09 '89 | Lidia Davidson-Randall |

DHMH-16 Rev 1/89

88 13128

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13159
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Regina GEPHARDT | | | 2. DATE OF DEATH (Month, Day, Year): May 23, 1989 | 3. TIME OF DEATH: 2:20 P M |
| 4. SOCIAL SECURITY NUMBER: 212-74-1349 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 25, 1907 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore, County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1311 Mohr's Lane | | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WNAT COUNTRY? |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): August Laubach | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Phiefer | |
| 19a. INFORMANT'S NAME (Type/Print): Harry Gephardt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1313 Mohr's Lane Balto. Md. 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: Connelly FuneralHome 300MAceAVe. 21221 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Anoxic Encephalopathy.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-23-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jonathan Seidenberg, M.D. 9000 Franklin Square Dr. Baltimore 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13160
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY A. GIORDANO | | | | 2. DATE OF DEATH (Month, Day, Year): 05 27 89 | 3. TIME OF DEATH: 9:20 P M |
| 4. SOCIAL SECURITY NUMBER: 213-34-4630 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH: Dec. 9, 1914 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Forest Hill | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2009 Phillips Mill Road | | 10f. ZIP CODE: 21050 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Vincinzo Caltagrione | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Bruno | |
| 19a. INFORMANT'S NAME (Type/Print): June Lynne Gutknecht | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2009 Phillips Mill Road, Forest Hill, Md. 21050 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 5-30-89 | 20c. LOCATION — City or Town, State: Parkville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks, Jr. | | 22. NAME AND ADDRESS OF FACILITY: 1050 York Rd. Ruck Towson Funeral Home, Towson, Md. 21204 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Oneet and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. RESPIRATORY FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury that initieted evente resulting in deeth) LAST | b. CHF | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
☒ 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Armin Azad, MD. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARMIN AZAD, M.D. G.B.M.C.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): JUN 01 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13161

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Nancy | JANE | Hall | 5 / 6 / 89 | 1:20 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 151 48 3410 | 1 ☐ M 2 ☒ F | 34 YRS. | | | 10 24 1955 | NEW JERSEY |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 5131 Sekots Road | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5131 SEKOT ROAD | 21207 | U. S. A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO | WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | COLLEGE | COST ANALYST | MARYLAND NATIONAL BANK |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| DAVID BANTA | PEGGY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MR. DWIGHT L. HALL, SR. | 172 WINTERS LANE BALTIMORE, MD. 21228 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State 21117 |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | GARRISON FOREST VETERANS CEM. | OWINGS MILLS, MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Herbert E. Nutter | NUTTER FUNERAL HOMES, INC. 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Multiple stab wounds and cuts
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: | OTHER: |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 5/6/89 | M | 1 ☒ YES 2 ☐ NO | Subject stabbed & cut |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 5131 Sekots Rd, Balto, MD. |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | OCME | ▶ 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Charles P. Kokes, M.D., Acting Deputy Chief 111 Penn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 10 1989 | Julia Davidson-Pendergast |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13162
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM MARTIN HOLLS | | 2. DATE OF DEATH (Month, Day, Year): 5 3 89 | 3. TIME OF DEATH: 9:20A M |
| 4. SOCIAL SECURITY NUMBER: 212-05-6547 | 5. SEX: XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-1-96 |
| 8. BIRTHPLACE (State or Foreign Country): New York | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Edenwald | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 800 Southerly Road | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWI | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): General Store Keeper | 16b. KIND OF BUSINESS/INDUSTRY: BG&E |
| 17. FATHER'S NAME (First, Middle, Last): William Holls | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Pnnaught | |
| 19a. INFORMANT'S NAME (Type/Print): William M. Holls Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2349 Riverbend Rd. Allentown Pa. 18103 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge | 20c. LOCATION — City or Town, State: Pikesville Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis J. Stephen Jenabs | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld 6500 York Road 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | ASCVD | 5 Yrs |
| DUE TO (OR AS A CONSEQUENCE OF): b. | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell | 29c. LICENSE NUMBER: D-09383 | 29d. DATE SIGNED (Month, Day, Year): 5/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell 7501 York Raod Towson, Md. 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Knudsen-Randall | |

DHMH-18 Rev 1/89

Sale! 89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13163 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Suzanne Weston Holley

**2. DATE OF DEATH**: Month 5, Day 3, Year 89

**3. TIME OF DEATH**: 2:30 p M

**4. SOCIAL SECURITY NUMBER**: 215-40-9750

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 73 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 8 9 15

**8. BIRTHPLACE** (State or Foreign Country): Rhode Island

**9a. FACILITY NAME** (If not institution, give street and number): 7005 Charles Ridge Road

**9b. CITY, TOWN OR LOCATION OF DEATH**: Towson

**9c. COUNTY OF DEATH**: Baltimore Co.

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Baltimore Co.

**10c. CITY, TOWN OR LOCATION**: Towson

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 7005 Charles Ridge Road

**10f. ZIP CODE**: 21204

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Herbert Weston

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Grace Richards

**19a. INFORMANT'S NAME** (Type/Print): Virginia H. Daschbach

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7005 Charles Ridge Road, Towson, Md. 21204

**20a. METHOD OF DISPOSITION**: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Greenmount Crematory

**20c. LOCATION — City or Town, State**: Baltimore City , Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ John D. Reed

**22. NAME AND ADDRESS OF FACILITY**: Mitchell-Wiedefeld Home
6500 York Rd., Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Lung Cancer — Approximate Interval: 10 months
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Charles Padgett MD

**29c. LICENSE NUMBER**: D15546

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5-4-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Dr. Charles Padgett 5601 Loch Raven Blvd., Baltimore, Maryland

**31. DATE FILED** (Month, Day, Year): MAY 9 1989

**32. REGISTRAR'S SIGNATURE**: Julie Davidson-Ramsey

DNMN-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13164
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anna C. Hagner | | | | 2. DATE OF DEATH (Month, Day, Year): 5 8 89 | 3. TIME OF DEATH: 12:35 a M |
| 4. SOCIAL SECURITY NUMBER: 216-03-4772 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-28-02 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home-Catonsville | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville, Md. | | 9c. COUNTY OF DEATH: Baltimore Co. |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: N/A | 10c. CITY, TOWN OR LOCATION: Baltimore, Md. | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 15 N. Wickham Rd. - Balto., Md. | | 10f. ZIP CODE: 21229 | | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: N/A | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: N/A | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive | | 16b. KIND OF BUSINESS/INDUSTRY: I. Miller & Son | |
| 17. FATHER'S NAME (First, Middle, Last): Henry Von Bauer | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Delices | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Margaret Schmidtbauer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1218 Poplar Ave.-Balto., Md. 21227 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____ 5-10-89 | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Pk.Cem. | | 20c. LOCATION — City or Town, State: Baltimore Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ G. Truman Schwab | | 22. NAME AND ADDRESS OF FACILITY: 5151 Baltimore National Pike Baltimore, Md. 21229 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Cerebro Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D26294
29d. DATE SIGNED (Month, Day, Year): ▶ 5/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1101 Marden Chase Lane - Balt 21239

31. DATE FILED (Month, Day, Year): 5/MAY 10 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13165
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| SAMUEL | W. | HENDLER | 5 4 89 | 07.10A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-05-3536 | 1 [X] M 2 [ ] F | 83 YRS. | | | MAY 13, 1905 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| BALTIMORE COUNTY GENERAL HOSPITAL | RANDALLSTOWN | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | BALTIMORE | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3198 OLD POST DRIVE, APT. 2 | (21208) | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | | OWNER | HENDLER POULTRY |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| MEYER HENDLER | ANNA MERKIN |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. PHYLLIS GLASSMAN | 3198 OLD POST DR, APT. 2 BALTO., MD 21208 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | BETH TFILOH CEMETERY | BALTIMORE, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Joel D Levinson | SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest & A.S.H.D. & D.M. | 14 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] M.D | D 22612 | ▶ 5/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 9 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 1315

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13166
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harvey A. Hunteman
2. DATE OF DEATH (Month, Day, Year): 5 10 89
3. TIME OF DEATH: 4:15 A M
4. SOCIAL SECURITY NUMBER: 215 12 6558
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/2/22
8. BIRTHPLACE (State or Foreign Country): Easton, MD
9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1627 Kirkwood Road
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): unknown — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): engineer
16b. KIND OF BUSINESS/INDUSTRY: AT & T
17. FATHER'S NAME (First, Middle, Last): Henry A. Hunteman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mable Schockley
19a. INFORMANT'S NAME (Type/Print): Ruth M. Hunteman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1627 Kirkwood Road Balto. MD 21207
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crest Lawn
20c. LOCATION — City or Town, State: Howard County, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ruth M. Hunteman
22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Estate, 736 Edmondson Ave. Balto. MD 21228

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arreat, shock, or heert failure. List only one cause on each line. — Approximate Interval Between Onset end Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Bronhogenic Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
c.
OUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
COPD
Cocowacy Artery Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John Tretter MD
29c. LICENSE NUMBER: D35906
29d. DATE SIGNED (Month, Day, Year): 5/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Tretter Baltimore County General Hospital, Randallstown MD
31. DATE FILED (Month, Day, Year): MAY 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

5+1

DHMH-16 Rev 1/89

89 1316

Item# 19a, 19b Film#g651 05/26/89 per F.H. da 7

89 13167

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|
| D. MURTY | HEJEEBU | 05 / 24 / 89 | 8:11 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-62-5311 | 1 ☒ M 2 ☐ F | 54 YRS. | | | 6/23/34 | INDIA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| BALTIMORE COUNTY GENERAL HOSPITAL | RANDALLSTOWN | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | RANDALLSTOWN | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3708 COURTLEIGH DRIVE | 21133 | INDIA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: EAST INDIAN (ASIAN |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 10 | MANUFACTURING CHEMIST | PEST CONTROL |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| KAMASWAR RAO | SURYAKANTAM |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ~~LEASHMI~~ LAKSHMI HEJEEBU | 3708 ~~COURTLEE~~ COURTLEIGH DRIVE RANDALLSTOWN MD 21133 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | WESTVIEW CREMATORY | WESTVIEW, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Russell Witzke | LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD 21228 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ischemic Cardiomyopathy | 2 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D32449 | ▶ 5/24/89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| DR. CLIFFORD AMEND | 1717 GWYN OAK AVENUE |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | Julia Davidson-Rudasill |

DHMH-16 Rev 1/89

89 13168

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM H. HUTSON
2. DATE OF DEATH: MONTH 5 DAY 21 YEAR 89
3. TIME OF DEATH: 6:18 M
4. SOCIAL SECURITY NUMBER: 212078596A
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): JULY 25, 1916
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: PARKVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 2911 SCHERER AVE.
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: W.W II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS; College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMP.-OWNER
16b. KIND OF BUSINESS/INDUSTRY: TRUCK CO.
17. FATHER'S NAME (First, Middle, Last): EDWARD T. HUTSON
16. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE F. KAPPLER
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN
20c. LOCATION — City or Town, State: GLEN BURNIE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ralph W. Evans, Jr.
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD-PARKVILLE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CONGESTIVE HEART FAILURE.

DUE TO (OR AS A CONSEQUENCE OF):

c. (L) CEREBROVASCULAR ACCIDENT = (R) HEMIPARESIS

DUE TO (OR AS A CONSEQUENCE OF):

d. S/P CORONARY ARTERY BYPASS.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ceballos, MD
29c. LICENSE NUMBER: D 25886
29d. DATE SIGNED (Month, Day, Year): 5/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CEBALLOS, M.D. - ST. JOSEPH HOSPITAL - TOWSON, MD 21204
31. DATE FILED (Month, Day, Year): MAY 26 1989
32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13169 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward J. Hartlove | | | 2. DATE OF DEATH Month: 5 Day: 18 Year: 89 | 3. TIME OF DEATH: 10:35 A M |
| 4. SOCIAL SECURITY NUMBER: 220-01-3067 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 6-27-06 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Summit Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4733 Amberly Avenue | | 10f. ZIP CODE: 21229 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper | | 16b. KIND OF BUSINESS/INDUSTRY: Maryland Drydock |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Hartlove | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy Naylor | | |
| 19a. INFORMANT'S NAME (Type/Print): Catherine Hartlove | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4733 Amberly Avenue Baltimore, MD 21229 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Teresa L Goff | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PR (-VE) Sepsis, Hypertension | |
| | DUE TO (OR AS A CONSEQUENCE OF): emphysema, CRF | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): thrombocyte penia, Ascite, | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Malnutrition, ASCVD | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] (44) | D31322 | 5/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PRADEEP GARG M.D.; 720 MAIDEN CH LN, Catonsville, Md 21228

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 19 1989 | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13170
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Evelyn Harper, Harrington | | | | 2. DATE OF DEATH (Month, Day, Year): 5 3 1989 | 3. TIME OF DEATH: 10 18 P M |
| 4. SOCIAL SECURITY NUMBER: 212-01-9518 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | | 7. DATE OF BIRTH (Month, Day, Year): 6-15-05 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Randallstown | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 10404 Liberty Road | | 10f. ZIP CODE: 21133 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): William Harper | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Leona Justus | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Irene Salemi | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10402 Liberty Road Randallstown, MD 21133 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Memorial Park | 20c. LOCATION — City or Town, State: Sykesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph J. W. Kellner | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, 8728 Liberty Road, Randallstown, MD 21133-4784 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Sepsis | 3wks |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Left Lower Lobe Pneumonia | 3wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Methicillin Resistant Staphylococcus Aureus | 3wk |
| DUE TO (OR AS A CONSEQUENCE OF): d. | Chronic Aspiration Pneumon | 2mths |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, Arteriosclerotic Vascular Disease
Acute Cerebrovascular Accident - R Temporal Lob
Atrial fibrillation, C. Difficile Colitis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gary A Manko | 29c. LICENSE NUMBER: D25062 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-3-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY A. MANKO MD, 11E Chestnut Hill Ln, Reisterstown, MD 21136 | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall | |

DHMH-16 Rev 1/89

89 13171

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

10

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Catherine HAYES | | | | | 2. DATE OF DEATH (Month, Day, Year): May 14, 1989 | | 3. TIME OF DEATH: 10:12A M |
| 4. SOCIAL SECURITY NUMBER: 213 18 3440 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): March 12 1917 | | 8. BIRTHPLACE (State or Foreign Country): Baltimore Md |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hopsital | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | | 10c. CITY, TOWN OR LOCATION: Essex | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 205 St. Mary's Rd. | | | 10f. ZIP CODE: 21221 | | | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Carr | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Kennedy | | |
| 19a. INFORMANT'S NAME (Type/Print): Charles Hayes, Husband | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 205 St. Mary's Rd. Balto., Md. 21221 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State: Baltimore Co., Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | | | | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto, Md. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary congestion | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Anasarca from liver failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Pancytopenia - poor immune function | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Decubitus Ulceration, Poor nutrition, Recent Sepsis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

26d. DESCRIBE HOW INJURY OCCURED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Van E. Lomis MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year) ▶ 5-14-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Van E. Lomis, MD 9000 Franklin Square Drive Baltimore, MD 21237

31. DATE FILED (Month, Day, Year): MAY 15 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13172

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helen L. HARDY | | | 2. DATE OF DEATH (Month, Day, Year): May 12, 1989 | 3. TIME OF DEATH: 7:15 A M |
| 4. SOCIAL SECURITY NUMBER: 216-30-9120 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 24,1906 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Joppa | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 227 Kershaw Ct. | | 10f. ZIP CODE: 21085 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cup Feeder | 16b. KIND OF BUSINESS/INDUSTRY: Cup Manufacturing Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Francis DeGrange | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Erma Viola Heffner | |
| 19a. INFORMANT'S NAME (Type/Print): Joan Degano | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 227 Kershaw Ct., Joppa, Md. 21085 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Howard Chapel Cemetery | 20c. LOCATION — City or Town, State: Long Corner, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth | | 22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitus
Dementia and Hydrocephalus

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Madhu Chandly | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MADHU CHANDLY Franklin Square. | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 Julie | 32. REGISTRAR'S SIGNATURE: Deborah Kendall | |

3

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13173 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GRACE E. HOUCK
2. DATE OF DEATH (Month, Day, Year): 5 - 1 - 89
3. TIME OF DEATH: 7 54 P M
4. SOCIAL SECURITY NUMBER: 213-10-7574
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-13-98
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO.
9c. COUNTY OF DEATH: BALTO.

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTO.
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8720 EMGE RD.
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): HARRY DONAHOO
18. MOTHER'S NAME (First, Middle, Maiden Surname): LOTTIE ROGERS
19a. INFORMANT'S NAME (Type/Print): MELVIN DONAHOO
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2417 PELHAM AVE 21213
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEM.
20c. LOCATION — City or Town, State: BALTO, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic obstructive Pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe rheumatoid arthritis
Anxiety depression

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gracito V. Patricio, M.D.P.A.
29c. LICENSE NUMBER: D08358
29d. DATE SIGNED (Month, Day, Year) ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): MAY 04 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13174
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Regina Marie HAGLAND | | | 2. DATE OF DEATH (Month, Day, Year): May 4, 1989 | 3. TIME OF DEATH: 6:02p M |
| 4. SOCIAL SECURITY NUMBER: 213187089 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05/16/1912 | 8. BIRTHPLACE (State or Foreign Country): Germany |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Rosedale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8023 Old Philadelphia Road | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES: | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Professional Driver | 16b. KIND OF BUSINESS/INDUSTRY: Seel-employed | |
| 17. FATHER'S NAME (First, Middle, Last): Ludwig Lackl | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Regina Neumeier | |
| 19a. INFORMANT'S NAME (Type/Print): Doris J. Wagner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8023 Old Phildelphia Road Balto. Md. 21237 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem. | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Cvach Funeral Home Inc. 1211 Chesaco Ave Rosedale F.H. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Anoxic encephalopathy and coma. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Hagan M.D. | 29c. LICENSE NUMBER: D37242 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Hagan, M.D. 9000 Franklin Square Dr., Balto., 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 4 - 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall |

DHMH-18 Rev 1/89

89 1317

Item #5 per FH film 651 5/31/89fj

89 13175

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): Margaret M. Hobner | | | 2. DATE OF DEATN Month: May Day: 19, Year: 1989 | 3. TIME OF DEATN: pM |
| 4. SOCIAL SECURITY NUMBER: 579-20-8370 | 5. SEX: 1 [X] M 2 [X] F | 6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 9, 1924 | 8. BIRTHPLACE (State or Foreign Country): Wash. D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 3333 Willoughby Road | 9b. CITY, TOWN OR LOCATION OF DEATN: Parkville | 9c. COUNTY OF DEATH: Baltimore | | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Parkville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 3333 Willoughby Road | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WNAT COUNTRY?: United States | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | | |
| 17. FATNER'S NAME (First, Middle, Last): Robert Barnes | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Hardy | | | |
| 19a. INFORMANT'S NAME (Type/Print): John H. Hobner | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3204 Sperl Ct. Baltimore, Md. 21234 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial 5/22/89 | 20c. LOCATION — City or Town, State: White Marsh, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Milton J. Knight Jr. Milton J. Knight Jr. | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Road 21214 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of lung c wide spread metastasis | ~8 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition
Diabetes mellitus

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATN: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Tah-Hsing Hsu MD | D05425 | ▶ May 20, 1989 |

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 23 1989 | Lois Tribbitt Rubin |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13176 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): PAUL C HESTER JR. | | | 2. DATE OF DEATH Month: 5 Day: 1 Year: 89 | 3. TIME OF OEATH: 2 25 P M |
| 4. SOCIAL SECURITY NUMBER: 220-13-9935 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 17 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10/11/71 | 8. BIRTHPLACE (State or Foreign Country): MAryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO, CO. Towson MD. | | 9c. COUNTY OF DEATH: BALTO | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 424 DELAWARE AVE. | 10f. ZIP CODE: ~~21221~~ 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): PAUL C. HESTER, SR. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY PETRI HESTER | |
| 19a. INFORMANT'S NAME (Type/Print): Paul Hester Sr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 424 Delaware Ave. Balto, Md. 21221 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Rossville Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 700 MACE AVE BALTO. 21221 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Renal Failure d/t Cystic Fibrosis | 17yr. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Congenital Atrophic Kidneys DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): None | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul A Mullan MD | | ▶ 5/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL A. MULLAN MD 7401 OSLER DR BALT 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 3 _ 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 1376

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13177
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Isadore ISADORE Horwitz | | | 2. DATE OF DEATH (Month, Day, Year): May 8 1989 | 3. TIME OF DEATH: 7 49 AM DST |
| 4. SOCIAL SECURITY NUMBER: 214-01-7729 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): DEC. 12, 1912 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO XX |
| 10e. STREET AND NUMBER: 28-E STOCKMILL RD. | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PHARMACIST | 16b. KIND OF BUSINESS/INDUSTRY: DRUGS |
| 17. FATHER'S NAME (First, Middle, Last): BENJAMIN HORWITZ | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DORA WEISBLATT | |
| 19a. INFORMANT'S NAME (Type/Print): DOROTHY HORWITZ | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28-E STOCKMILL RD. BALTO., MD 21208 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SHAAREI TFILOH CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joel D Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | 2 1/2 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Coronary Heart Disease | 10 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Hypercholesterolemia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Henry I. Babitt M.D. | 29c. LICENSE NUMBER: D00337 | 29d. DATE SIGNED (Month, Day, Year): ▶ May 8, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Henry I. Babitt M.D 2724 North Charles St. Balto, Md 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau |

DNMN-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13178
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lucille M. Hawkins | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 20 / 89 | 3. TIME OF DEATH: 10:13 A M |
| 4. SOCIAL SECURITY NUMBER: 217-34-2644 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 54 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-9-34 | 8. BIRTHPLACE (State or Foreign Country): N. CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown Baltimore County | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3520 Hillsmere Rd | | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY: Housewife |
| 17. FATHER'S NAME (First, Middle, Last): William Jackson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth M. ONeil | | |
| 19a. INFORMANT'S NAME (Type/Print): GEORGE A. HAWKINS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3520 Hillsmere Rd BAHO, MD 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CREST LAWN MEMGARDENS | | 20c. LOCATION — City or Town, State: HOWARD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Herbert E. Nutter | | 22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOMES INC. 21216 2501 GWYNNS FALLS PARKWAY | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypertension | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Clifford L. Amend M.D. | D32449 | ▶ 5/20/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Clifford L. Amend M.D. 1717 Gwynn Oak Ave. Baltimore Md 21207

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | Division Registrar |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13179
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary P. Haynie | | | 2. DATE OF DEATH (Month, Day, Year): 05 11 89 | 3. TIME OF DEATH: 9:55 a M |
| 4. SOCIAL SECURITY NUMBER: 215-09-2466 | 5. SEX: 1 ☐ M 2 ☐ F XX | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/23/14 | 8. BIRTHPLACE (State or Foreign Country): Baltimore, MD |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 503 Dogwood Lane | 10f. ZIP CODE: 21204 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): William R. Phipps | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rita George | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Lura Vogelman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 620 Overbrook Road Baltimore, Md. 21212 | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Pikesville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastic Breast CA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert D'Amato M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Robert D'Amato, M.D. G.B.M.C.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-18 Rev 1/89

10

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13180

**TO BE COMPLETED BY FUNERAL DIRECTOR**

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|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rita Maria Hammel | | | 2. DATE OF DEATH (Month, Day, Year): 5-8-89 | 3. TIME OF DEATH: 12:00PM M |
| 4. SOCIAL SECURITY NUMBER: 642-94-3189 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 20,1951 | 8. BIRTHPLACE (State or Foreign Country): Ecuador |
| 9a. FACILITY NAME (If not institution, give street and number): 7 Shawnee Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7 Shawnee Street , Apt. 101 | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

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|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: — |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): William Victor Chizmar | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Olga Beatriz Barriga |
| 19a. INFORMANT'S NAME (Type/Print): William V. Chizmar | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1920 Hanson Road, Edgewood,Md. 21040 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | 20c. LOCATION — City or Town, State: Bel Air, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K. McComas III | 22. NAME AND ADDRESS OF FACILITY: Howard K.McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon,Md. 21009 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, euch ea cardiec or reepiratory arrest, ahock, or heert feilure. Liet only one ceuse on aach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel diseese or condition reeulting in death) → | a. Desipramine Intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentielly liet conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Diseese or injury thet initieted evente reeulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not reeulting in the underlying ceuse given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5-8-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject used drugs |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 7 Shawnee Street,Balto.Co.MD |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-9-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 10 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13181
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN GRACE HENNEBERGER | | | 2. DATE OF DEATH (Month, Day, Year): MAY 2, 1989 | 3. TIME OF DEATH: 10:15 P M |
| 4. SOCIAL SECURITY NUMBER: 214-38-1971 B | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 98 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 10, 1890 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 229 Blenheim Rd. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 229 Blenheim Rd. | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 Years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph W. Cathcart | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MAry Winters | |
| 19a. INFORMANT'S NAME (Type/Print): Nadine H. Sanborn | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 Blenheim Rd. BaLTIMORE, Md. 21212 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephen Venakis | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive heart failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiomyopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary heart disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile Dementia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D53897 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert J. Vissing, M.D. 4300 N. Charles St. Baltimore, Md. 21218 | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13182 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gladys L. Hardesty | | | | 2. DATE OF DEATH (Month, Day, Year): 5/26/89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 216-12-8906 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7/23/13 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): 2716 Alderwood Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore Highlands | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2716 Alderwood Road | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: own home | |
| 17. FATHER'S NAME (First, Middle, Last): Otho Mears | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Monnie Cobb | | |
| 19a. INFORMANT'S NAME (Type/Print): J. Guy Hardesty | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2716 Alderwood Road, Baltimore, MD 21227 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State: Dorsey, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebro vascular accident | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertension. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D26307 | ▶ 5/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3927 Annapolis Rd. Baltimore MD 21227

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 31 1989 | [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13183

DIVISION OF VITAL RECORDS, P.O. BOX 12 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1-27 are to be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, PART 2 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helen Logan Humphrey | | | | 2. DATE OF DEATH (Month, Day, Year): May 7, 1989 | 3. TIME OF DEATH: 1:00 A M |
| 4. SOCIAL SECURITY NUMBER: 183-18-7128 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): March 18, 1921 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 20430 Downes Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Parkton | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Parkton | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 20430 Downes Road | 21120 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12): 9 | College (1-4 or 5+): | Assembler | Tool Mfg. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Lawrence Simpson | Blanche Hunt |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert W. Humphrey | 1017 Jordan Saw Mill Rd., Parkton, MD 21120 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Stablers Cemetery | Parkton, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ J. Hartenstein | J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Coronary Heart Disease | 15 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. High Blood Pressure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 5/7/89 | — M | 1 ☐ YES 2 ☐ NO | — |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) — |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ronald L. Bruhathen MD | D15288 | ▶ 5/10/89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Hunt Valley MED ER | Cockeysville, MD 21030 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 17 1989 | Lois Tolson-Pinder |

10

DHMH-16 Rev 1/89

89 13184

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CATHERINE HAZARD | | | | | 2. DATE OF DEATH MONTH 5 DAY 27 YEAR 89 | | 3. TIME OF DEATH 2:50 A M |
| 4. SOCIAL SECURITY NUMBER: 216-24-1351 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-1-04 | | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GBMC | | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | | 9c. COUNTY OF DEATH: BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | | 10c. CITY, TOWN OR LOCATION: Towson | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 34 Alanbrooke Ct. | | | 10f. ZIP CODE: Towson | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 Yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | | |
| 17. FATHER'S NAME (First, Middle, Last): Jay Harry Barnes | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Sullivan | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert C. Hazard | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 34 Alanbrooke Ct. Towson, Md. 21204 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory | | 20c. LOCATION — City or Town, State: Baltimore City | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. RESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. LUNG CARCINOMA WITH WIDESPREAD METATASES

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Rebecca A Ludwig MD | D36226 | ▶ 5-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): REBECCA A. LUDWIG, MD GBMC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| JUN 01 1989 | Julie Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13185
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sean Peter Houlihan | | | | | 2. DATE OF DEATH: MONTH 4-27-89 DAY YEAR | 3. TIME OF DEATH: 2:30A M |
| 4. SOCIAL SECURITY NUMBER: 218-88-8040 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 23 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-5-1965 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): E. bound Route 166 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore County | | | 9c. COUNTY OF DEATH: Baltimore County |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Wicomico | 10c. CITY, TOWN OR LOCATION: Salisbury | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Camden Ave. | 10f. ZIP CODE: 21801 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 6 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: Medical School |
| 17. FATHER'S NAME (First, Middle, Last): Peter Houlihan, Jr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosalie Chamberlin | |
| 19a. INFORMANT'S NAME (Type/Print): Peter Houlihan, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Camden Ave. Salisbury, Maryland | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Henlopen Crematory | 20c. LOCATION — City or Town, State: Lewes, Delaware |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald C Bounds | | 22. NAME AND ADDRESS OF FACILITY: Bounds Funeral Home Salisbury, Maryland | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) scene | |
| 27. MANNER OF DEATH: 1 [ ] Natural [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-27-89 / 28b. TIME OF INJURY: 2:30A M / 28c. INJURY AT WORK? 1 [ ] YES [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/fixed object |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Route 166, Baltimore Co. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 4-27-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): APR 28 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 13182

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13186
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN WILLIAM HARTMANN | | | 2. DATE OF DEATH (Month, Day, Year): 5 10 89 | 3. TIME OF DEATH: 2:20 PM |
| 4. SOCIAL SECURITY NUMBER: 214-03-1339 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 01-02-05 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): HOLLY HILL MANOR NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Parkville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3322 Texas Avenue | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Silversmith | 16b. KIND OF BUSINESS/INDUSTRY: Samuel Kirk & Son | |
| 17. FATHER'S NAME (First, Middle, Last): Henry Jacob Hartmann | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine L. Blum | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Robert A. Hartmann | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3322 Texas Avenue Baltimore Maryland 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Mausoleum 5/12/89 | 20c. LOCATION — City or Town, State: Baltimore Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Ruck | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc. 5305 Harford Rd. 21214 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CANCER OF THE LUNG

DUE TO (OR AS A CONSEQUENCE OF):

c. CONGESTIVE HEART FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harold M. Hammerschlag MD | 29c. LICENSE NUMBER: D07697 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers |

DHMH-16 Rev 1/89

89 13187

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John Elmer HALLER | | | 2. DATE OF DEATH (Month, Day, Year): May 11, 1989 | 3. TIME OF DEATH: 12:08 a M |
| 4. SOCIAL SECURITY NUMBER: 219-01-6138 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/28/08 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Essex | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8315 Bear Creek Drive | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber/Welder | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Haller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Lanahan | |
| 19a. INFORMANT'S NAME (Type/Print): Blanche H. Sheets | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8315 Bear Creek Drive Baltimore, Md. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jackie N. Shannon | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. unresectabel bronchogenic carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: N. Khanna | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year) ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Naresh Khanna, M.D. 6660 Belair Road Baltimore, Md. 21206

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

2071

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13188
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Sidney Bruce Humphrey / BRUCE HUMPHREY | | | 2. DATE OF DEATH MONTH 5 DAY 21 YEAR 89 | 3. TIME OF DEATH 1037 AM |
| 4. SOCIAL SECURITY NUMBER 485-14-5418 | 5. SEX 1 M 2 F | 6. AGE (In yrs. last birthday) 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 7-27-27 | 8. BIRTHPLACE (State or Foreign Country) IOWA |
| 9a. FACILITY NAME (If not institution, give street and number) ST. JOSEPH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH Towson ~~BALTO. COUNTY~~ | | 9c. COUNTY OF DEATH BALTO |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MD | 10b. COUNTY HARFORD | 10c. CITY, TOWN OR LOCATION BEL AIR | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER 12 Mc GREGOR WAY | | 10f. ZIP CODE 21014 | 10g. CITIZEN OF WHAT COUNTRY? U.S |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES: WWII & Korea | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) President | 16b. KIND OF BUSINESS/INDUSTRY Chemical Corporation |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) Clyde George Humphrey | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lily Margaret Miller |
| 19a. INFORMANT'S NAME (Type/Print) Alice C. Humphrey | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 McGregor Way, Bel Air, Md. 21014 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens | 20c. LOCATION — City or Town, State Bel Air, Md. 21014 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard K McComas III | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE MYOCARDIAL INFARCTION | 8 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Staff Physician | 29c. LICENSE NUMBER D 30263 | 29d. DATE SIGNED (Month, Day, Year) 5-21-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS T. KHOD ST. JOSEPH HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year) MAY 23 '89 | 32. REGISTRAR'S SIGNATURE | |

DHMH-16 Rev 1/89

88 13188

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13189
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel Hughes
2. DATE OF DEATH (Month, Day, Year): May 24, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 218-12-0223 A
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): May 2, 1901
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3627 Marriotts Lane
9b. CITY, TOWN OR LOCATION OF DEATH: Rock Dale
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Rock Dale
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3627 Marriotts Lane
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Customer Relations
17. FATHER'S NAME (First, Middle, Last): Thomas E. Cross
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Hand
19a. INFORMANT'S NAME (Type/Print): Howard John Hughes
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3627 Marriotts Lane Baltimore, MD 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph W Kellner
22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, 8728 Liberty Road, Randallstown, MD 21133-4784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Acute Myocardial Infarct — Unk.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerosis —
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible], M.D.
29c. LICENSE NUMBER: D030738.
29d. DATE SIGNED (Month, Day, Year): 5/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5310 Old Court Rd. Randallstown, Md. 21133
31. DATE FILED (Month, Day, Year): MAY 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13190
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Dorothy S. Isphording | | | 2. DATE OF DEATH: MONTH 05 DAY 10 YEAR 89 | 3. TIME OF DEATH: 1:45 pM |
| 4. SOCIAL SECURITY NUMBER: 292-12-7504 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08/20/23 | 8. BIRTHPLACE (State or Foreign Country): Lakewood Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1215 Ridervale Road | | 10f. ZIP CODE: 21204 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs; College (1-4 or 5 +): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home |
| 17. FATHER'S NAME (First, Middle, Last): Ernst Stuehm | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora Ranker | | |
| 19a. INFORMANT'S NAME (Type/Print): Richard B. Isphording | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1215 Ridervale Rd. Towson, Md. 21204 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns. 5/15/89 | | 20c. LOCATION — City or Town, State: Timonium, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas J. Smith | | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Breast Cancer with metastasis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| A Serafis M.D. | | 5/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Anthony Serafis, M.D. G.B.M.C.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | Julia Davidson-Landeck |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13191

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Pearl Justice | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 16 / 89 | 3. TIME OF DEATH: 6:42 PM |
| 4. SOCIAL SECURITY NUMBER: 217-14-0539 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/8/04 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): University of Maryland Hospital E/R | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD 21201 | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Seton Hill Manor Nursing Home 501 W. Franklin | | 10f. ZIP CODE: 2120 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Restaurant Worker | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Johnnie Watson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Watson |
| 19a. INFORMANT'S NAME (Type/Print): Seton Hill Manor N. Home | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 501 W. Franklin St Balto MD |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Zion | 20c. LOCATION — City or Town, State: Balto. Co., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Irvin Carroll | 22. NAME AND ADDRESS OF FACILITY: Irvin Carroll Funeral Home 1712-14 W. North Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | 1 hr 15 mins |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency
Anemia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5/16/89 | 28b. TIME OF INJURY: ~5:30 PM | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Natural |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Nursing Home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Scott M. Hamilton, MD (JAR) | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): University of MD Hospital, 22 Greene Street 21201, Scott Hamilton MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 5/16/89 MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13192
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Clifton L. Jackson | | | | 2. DATE OF DEATH (Month, Day, Year): 5 11 89 | 3. TIME OF DEATH: A M |
| 4. SOCIAL SECURITY NUMBER: 213-07-6115 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-23-1912 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 2911 Salisbury Ave. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Edgemere | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Edgemere, Md. 21219 | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2911 Salisbury Ave. | | 10f. ZIP CODE: 21219 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker | 16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Clifton Raymond Jackson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Salley Izen | |
| 19a. INFORMANT'S NAME (Type/Print): Raymond Jackson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8195 Grayhaven Rd. Dundalk, Md. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Cremetory | 20c. LOCATION — City or Town, State: Silver Spring, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home, Inc. 2134 Willow Spring Rd. Dundalk, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Wallach MD | 29c. LICENSE NUMBER: D26835 | 29d. DATE SIGNED (Month, Day, Year): 5/11/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dawson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13193
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM ALFRED JARRIEL | | | 2. DATE OF DEATH (Month, Day, Year): 05/09/89 | 3. TIME OF DEATH: 4:45 P M |
| 4. SOCIAL SECURITY NUMBER: 212-36-8881 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 50 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-16-1939 | 8. BIRTHPLACE (State or Foreign Country): Georgia |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford County | 10c. CITY, TOWN OR LOCATION: Bel Air | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 204 Foxhall Drive, Apt. I | | 10f. ZIP CODE: 21014 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Army-Vietnam | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Longshoreman | 16b. KIND OF BUSINESS/INDUSTRY: Local 333 | |
| 17. FATHER'S NAME (First, Middle, Last): Manson Jarriel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sally Wilcher | |
| 19a. INFORMANT'S NAME (Type/Print): Velma M. Jarriel | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 Foxhall Drive, Apt. I, Bel Air, MD 21014 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery 5/12/89 | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Collins | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue, Baltimore, Maryland 21222 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 ... for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LUNG CANCER

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Alban B Bacchus MD | 29c. LICENSE NUMBER: D36292 | 29d. DATE SIGNED (Month, Day, Year): 5.9.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALBAN B. BACCHUS

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 Julia | 32. REGISTRAR'S SIGNATURE: Denderson Ruddick |

4+1

DHMH-16 Rev 1/89

Items 23a thu 28f Per M.E. FilmG652 6/19/89 CG

89 13194

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Travis Triston Jacobs | | 2. DATE OF DEATH (Month, Day, Year): 5 / 6 / 89 | 3. TIME OF DEATH: 4:12 P M |
| 4. SOCIAL SECURITY NUMBER: NA | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 1 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11/16/87 — 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph's Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towspn | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: COCKEYSVILLE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 307 LIMESTONE VALLEY DRIVE APT. F. | | 10f. ZIP CODE: 21030 | 10g. CITIZEN OF WHAT COUNTRY: USA |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHILD | 16b. KIND OF BUSINESS/INDUSTRY: NA |
| 17. FATHER'S NAME (First, Middle, Last): ALCOTT JACOBS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARYANNE HUGHES | |
| 19a. INFORMANT'S NAME (Type/Print): ALCOTT & MARYANNE JACOBS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 307 LIMESTONE VALLEY DRIVE APT F, COCKEYSVILLE, MD | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEM GARDENS | 20c. LOCATION — City or Town, State: TOWSON, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Anthony E. Ward Jr. | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Asthma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶5/7/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D., Acting Deputy Chief 111 Penn St. Balto.MD. | | |
| 31. DATE FILED (Month, Day, Year): MAY 11 '89 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13195
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EUGENE JOHNSON | | | | | 2. DATE OF DEATH (Month, Day, Year): 5-19-1989 | | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 227-18-2997 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS 1 DAYS 0 | IF UNDER 24 HRS.: HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year): 04-19-20 | | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): 2988 Sollers Point Rd. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | | 9c. COUNTY OF DEATH: BALTIMORE | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | | 10c. CITY, TOWN OR LOCATION: DUNDALK | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 2988 SOLLERS POINT ROAD | | | 10f. ZIP CODE: 21222 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4 or 5+): N/A | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ROD & WIRE MILL | | | 16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL CORP. | |
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH JOHNSON | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): AMANDA COLLINS | | |
| 19a. INFORMANT'S NAME (Type/Print): MERLE JOHNSON | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2988 SOLLERS POINT ROAD BALTIMORE, MARYLAND 21222 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): GARDENS OF FAITH CEMETERY 5-22-89 | | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott P. Handson | | | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc, 7922 Wise Ave. Dundalk, Md. 21222 | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory srreat, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pancreatic Carcinoma c Metastasis

DUE TO (OR AS A CONSEQUENCE OF):
b. Metastatic Liver Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Benign prostate Hypertrophy

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: D 27670

29d. DATE SIGNED (Month, Day, Year): 5/19/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Lin, M.D., 8903 Harford Rd., Balto., Md. 21234

31. DATE FILED (Month, Day, Year): MAY 21 1989

32. REGISTRAR'S SIGNATURE: Stella Davidson-Randall

OHMH-16 Rev 1/89

88 13102

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13196

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the physician attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached & use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS S. JOHNSON, JR. | | | 2. DATE OF DEATH: MONTH 5 DAY 9 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 214-14-3623 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-16-20 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 142 Winters Lane | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | 9c. COUNTY OF DEATH: Balto. | | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Balto. | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 142 Winters Lane | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-Employee | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas S. Johnson, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena | | |
| 19a. INFORMANT'S NAME (Type/Print): Arnetta Johnson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 142 Winters Lan. Catonsville, Md. 21228 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cem. | 20c. LOCATION — City or Town, State: Catonsville, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary P. Marsh | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave. | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cardiac arrhythmia probable
DUE TO (OR AS A CONSEQUENCE OF):
b. congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
c. bi valvular replacement
DUE TO (OR AS A CONSEQUENCE OF):
d. (aortic & mitral)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| George S. Thomas MD | 034385 | May 10, 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEORGE S. THOMAS.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13197
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page [illegible] be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner [illegible] at once.**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary A. Jirecek | | | | | 2. DATE OF DEATH: MONTH 4 DAY 28 YEAR 89 | 3. TIME OF DEATH: 8 45 P M |
| 4. SOCIAL SECURITY NUMBER: 219-10-0322 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan. 25, 1914 | 8. BIRTHPLACE (State or Foreign Country): Baltimore |
| 9a. FACILITY NAME (If not institution, give street and number): 936 Fordwood Circle | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: BALTIMORE | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore | | 10c. CITY, TOWN OR LOCATION: ---------- | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 936 Fordwood Circle | | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales | | 16b. KIND OF BUSINESS/INDUSTRY: Clothing | |
| 17. FATHER'S NAME (First, Middle, Last): Herbert H. VanRossum | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara C. Rohleder | |
| 19a. INFORMANT'S NAME (Type/Print): Frank Jirecek - husband | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 936 Fordwood Circle Baltimore, MD 21228 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bohemian National | | 20c. LOCATION — City or Town, State: Baltimore | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Curtis Gough | | | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore MD 21213 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [illegible] M.D. | D11171 | ▶ 4/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5550 BALTO. NAT'L PK - CATONSVILLE 21228 MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 1 - 1989 | [illegible] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13198

DIVISION OF VITAL RECORDS, P.O. B[illegible]3146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Virgil J. Kidwell | | | | 2. DATE OF DEATH MONTH: 5 DAY: 29 YEAR: 89 | 3. TIME OF DEATH: 7:45 PM |
| 4. SOCIAL SECURITY NUMBER: 234-64-1512 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 49 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-05-39 | 8. BIRTHPLACE (State or Foreign Country): West. V |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson MD 21204 | | 9c. COUNTY OF DEATH: BALTO | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | White Marsh | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5711 Keithley Rd. | 21162 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [✓] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 yrs. | | Machinist | Westinghouse |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Virgil P. Kidwell | Avis Radabaugh |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sandra K. Kidwell | 5711 Keithley Rd. White Marsh Maryland 21162 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Criss Cemetery | Mt. Nebo, West Va. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Lassahn Funeral Home | Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Heart Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Adenocarcinoma with Liver Metastasis

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ethan Spiegler MD | D34502 | ▶ 5-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ETHAN SPIEGLER ST JOSEPH HOSPITAL

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 31 1989 | Julia Davidson-Randall |

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DHMH-18 Rev 1/89

ITEM #11 7 #18 FILM #G651 5/26/89 PER: F. H. JA 7

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13199

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDGAR KEMPNER (EDGAR KEMPNER) | | | 2. DATE OF DEATH (Month, Day, Year): 5 17 89 | | 3. TIME OF DEATH: 0815 M |
| 4. SOCIAL SECURITY NUMBER: 232-26-1260 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/16/20 | | 8. BIRTHPLACE (State or Foreign Country): POLAND |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: OWINGS MILLS | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO | |
| 10e. STREET AND NUMBER: 3-D REGALIA CT. | | 10f. ZIP CODE: 21117 | | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: ~~1~~ ~~Never Married~~ 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EXECUTIVE | | 16b. KIND OF BUSINESS/INDUSTRY: T.V. REPAIR | |
| 17. FATHER'S NAME (First, Middle, Last): ADOLF KEMPNER | | 18. MOTHER'S NAME (First, Middle, Maiden Sr.): HELENE YOVKLAWITZ (UNKNOWN) | | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. DOROTHY KEMPNER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3-D REGALIA CT. OWINGS MILLS, MD 21117 | | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO (ARLINGTON) | | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney L. Stillman | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

25. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC ADENOCARCINOMA OF LUNG | 0 minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHF, RENAL FAILURE.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD | 29c. LICENSE NUMBER: D37333 | 29d. DATE SIGNED (Month, Day, Year): 5.17.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI Baltimore Co. Gen. Hospital | | |
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13200

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert F. KNIGHT
2. DATE OF DEATH (Month, Day, Year): May 19, 1989
3. TIME OF DEATH: 9:45 A M
4. SOCIAL SECURITY NUMBER: 218 01 4052
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/23/1915
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Rosedale, Md.
9c. COUNTY OF DEATH: Baltimore County

**RESIDENCE OF DECEDENT**

10a. STATE: Md.
10b. COUNTY: Balto.
10c. CITY, TOWN OR LOCATION: 518 New Pittsburgh Dundalk, Md.
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 518 New Pittsburgh
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ___ College (1-4 or 5+): ___
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bethlehem Steel
16b. KIND OF BUSINESS/INDUSTRY: Steel
17. FATHER'S NAME (First, Middle, Last): Leon Knight
18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Thompson
19a. INFORMANT'S NAME (Type/Print): Jacqueline Knight
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 New Pittsburgh Ave. Balto.,Md. 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ___
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. National Mem Pk.
20c. LOCATION — City or Town, State: Laurel, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto.,Md. 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. End Stage Chronic Obstructive Pulmonary Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Rosie Walker-McNair, MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): May 19, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rosie Walker-McNair M.D. 9000 Franklin Sq. Dr. 21237
31. DATE FILED (Month, Day, Year): MAY 22 1989
32. REGISTRAR'S SIGNATURE: Julia Pearson-Rudasa

DHMH-16 Rev 1/89

89 13500

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13201

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie Karaskevitch | | | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 22 / 89 | 3. TIME OF DEATH: 6:30 p M |
| 4. SOCIAL SECURITY NUMBER: 215-03-9925 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-30-15 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Frederick Villa Nursing Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 938 Wilton Drive | | 10f. ZIP CODE: 21227 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 8 +): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | | | 16b. KIND OF BUSINESS/INDUSTRY: J. Schoenemans | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Karaskevitch | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Laukasitis | |
| 19a. INFORMANT'S NAME (Type/Print): Dorothy Doll | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4813 Wilkens Avenue Baltimore, MD 21229 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie A. Shannon | | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Renal Failure | 2 Mos. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Severe atherosclerotic Cardiovasc dis. | yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypertension. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypothyroidism, Renal insufficiency, Senile Dementia 2° to Cerebral vasc.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: , MD. | 29c. LICENSE NUMBER: D. 18393 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-23-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. P. Malayaman, MD 4001 Wilkens Ave Balto 21229 | | |
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall | |

DHMH-16 Rev 1/89

88 13501

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13202
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALPHEUS KOHLBAUER | | | 2. DATE OF DEATH (Month, Day, Year): 05 18 1989 | 3. TIME OF DEATH: 1259 PM |
| 4. SOCIAL SECURITY NUMBER: 212-07-0814 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/06/14 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH'S HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO, MD. | | 9c. COUNTY OF DEATH: BALTO |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6857-D QUEENSFERRY RD | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY? XXXXXX U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [XX] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Rep. | 16b. KIND OF BUSINESS/INDUSTRY: Kebbler Bakery |
| 17. FATHER'S NAME (First, Middle, Last): Alpheus Joseph Kohlbauer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Una Byrne | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy R. Kohlbauer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6857 - D Queensferry Rd. Balto. Md. 21239 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Entombment | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Maus. | 20c. LOCATION — City or Town, State: Lutherville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Kratz | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Severe Chronic Obstructive Lung Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Coronary Artery Disease
Arteriosclerotic Cardiovascular Disease

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Beatrice P. Dixon, M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5/18/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BEATRICE P. DIXON St. Joseph Hospital, Towson, Md. | | |
| 31. DATE FILED (Month, Day, Year): MAY 22 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13203
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HENRY A. KOWALEVICZ | | | | 2. DATE OF DEATH (Month, Day, Year): MAY 13, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 219-07-4149 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-23-1921 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 7513 HOLABIRD AVENUE | | | 9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7513 HOLABIRD AVENUE | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3D GRADE; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TUNNEL KIEL FIREMAN | 16b. KIND OF BUSINESS/INDUSTRY: LOCK INSULATOR | |
| 17. FATHER'S NAME (First, Middle, Last): THEODORE KOWALEVICZ | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): TILLIE (NOT KNOWN) | |
| 19a. INFORMANT'S NAME (Type/Print): EVELYN M. KOWALEVICZ | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7513 HOLABIRD AVENUE DUNDALK, MARYLAND 21222 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEMETERY 5-16-89 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gregory E Reed | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CANCER OF LUNG | 12 mm. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Matthew M Rumbelow MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE |

DNMN-16 Rev 1/89

89 13204

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH RIDGELY KASTENDIKE | | | | 2. DATE OF DEATH (Month, Day, Year): May 9, 1989 | 3. TIME OF DEATH: 9:30 PM |
| 4. SOCIAL SECURITY NUMBER: 218-12-3575 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JAN 4, 1922 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): 6652 WALNUT WOOD CIR. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTO. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTO. | 10c. CITY, TOWN OR LOCATION: BALTO. | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6652 WALNUT WOOD CIR. | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): THERAPIST | 16b. KIND OF BUSINESS/INDUSTRY: WM. BAER SCHOOL |
| 17. FATHER'S NAME (First, Middle, Last): CHASE RIDGELY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): KATHERINE SUPPLE | |
| 19a. INFORMANT'S NAME (Type/Print): T. GRAHAM KASTENDIKE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 SILVER STIRRUP CT. TIMONIUM MD. 21093 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY | 20c. LOCATION — City or Town, State: PIKESVILLE MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edison M. Perkins Jr. | | 22. NAME AND ADDRESS OF FACILITY: H.W. JENKINS AND SONS CO. | 4905 YORK RD. BALTO. MD 21212 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hypertensive ASCVD | 10± yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles F. O'Donnell MD | D-09383 | ▶ May 10, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell MD - 7501 York Rd Towson MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Linda Davidson-Randall |

DHMH-15 Rev 1/89

88 1350

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13205 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): JUNE C KAVANAUGH
2. DATE OF DEATH: MONTH 5 DAY 9 YEAR 89
3. TIME OF DEATN: 6.15 A.M.
4. SOCIAL SECURITY NUMBER: 219-12-8878
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/10/25
8. BIRTNPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): 1145 GRANVILLE RD
9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE
9c. COUNTY OF DEATN: BALTO

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTO
10c. CITY, TOWN OR LOCATION: CATONSVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1145 GRANVILLE RD
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: W

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: —

17. FATHER'S NAME (First, Middle, Last): WILLIAM EVANS
18. MOTNER'S NAME (First, Middle, Maiden Surname): EVELYN SUMMERS

19a. INFORMANT'S NAME (Type/Print): JOHN J. KAVANAUGH
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1145 GRANVILLE RD CATONSVILLE MD 21207

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL
20c. LOCATION — City or Town, State: BALTO MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward J Weber
22. NAME AND ADDRESS OF FACILITY: EDWARD J WEBER F.H. 5311 EDMONDSON AVE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary edema
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. COPD
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertensive ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
d. Sepsis

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John H Shaw M.D.
29c. LICENSE NUMBER: D12967
29d. DATE SIGNED (Month, Day, Year): ▶ 5/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): John H Shaw MD 5800 Edmondson Ave Bal. 21228
31. DATE FILED (Month, Day, Year): MAY 9 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

88 13502

89 13206

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician; pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE L. KOLEGO | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 7 / 1989 | 3. TIME OF DEATH: 6:44 AM |
| 4. SOCIAL SECURITY NUMBER: 368-12-0512 | 5. SEX: 1 X M 2 F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04/10/17 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): G.B.M.C. 6701 N. CHARLES ST | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD 21204 | | 9c. COUNTY OF DEATH: BALTIMORE | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: LUTHERVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO | |
| 10e. STREET AND NUMBER: 139 WESTBURY Road | | 10f. ZIP CODE: 21093 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO; IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs.; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator | 16b. KIND OF BUSINESS/INDUSTRY: United Stripping Co. | | |
| 17. FATHER'S NAME (First, Middle, Last): John Kolego | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Anderson | | | |
| 19a. INFORMANT'S NAME (Type/Print): Gertrude M. Kolego | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 139 Westbury Road Lutherville, Md. 21093 | | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gard. 5-10-89 | 20c. LOCATION — City or Town, State: Timonium, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr. | 22. NAME AND ADDRESS OF FACILITY: 1050 York Rd. 21204 Ruck Towson Funeral Home, Inc. Towson, Md. | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HSCVD | Sudden |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO

25. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ Outpatient 3 X DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural; 2 ☐ Accident; 3 ☐ Suicide; 4 ☐ Homicide; 5 ☐ Pending Investigation; 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |
| 28e. PLACE OF INJURY -- At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | | | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles F. O'Donnell MD | D-09383 | ▶ 7 May 89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell MD - 7501 York Rd Towson MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 8 1989 | Julie Davidson-Randall |

DHMH-18 Rev 1/89

89 13207

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MIRIAM KALISH / MIRIAM KALISH | | | | 2. DATE OF DEATH (Month, Day, Year): 5 9 89 | 3. TIME OF DEATH: 0250 AM |
| 4. SOCIAL SECURITY NUMBER: 218 18 7776 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-22-22 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore Co. Gen Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4315 Labyrinth Rd APT. T-3 | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Book Keeper | 16b. KIND OF BUSINESS/INDUSTRY: CITY OF BALTIMORE | |
| 17. FATHER'S NAME (First, Middle, Last): SAM FEIT | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA KOVITZ | |
| 19a. INFORMANT'S NAME (Type/Print): LEONARD KALISH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4315 LABYRINTH RD., APT. T-3 BALTO., MD 21215 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HAR SINAI BENEVOLENT SOCIETY | 20c. LOCATION — City or Town, State: ROSEDALE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC,. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiomyopathy Etiology? | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Dehydration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| B Kutsche MD | D-35788 | 5/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): B KUTSCHE MD — BALTIMORE COUNTY GEN HOSP 5401 OLD COURT RD — RANDALLSTOWN MD 21133

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 13208

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BENJAMIN KURLANDER | | | | 2. DATE OF DEATH MONTH 5 DAY 19 YEAR 89 | 3. TIME OF DEATH 10 10P M |
| 4. SOCIAL SECURITY NUMBER: 215 05 1267 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/5/17 | 6. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSP. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 7907 CRISFORD PLA., APT. H | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANAGER | 16b. KIND OF BUSINESS/INDUSTRY: RETAIL | |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL KURLANDER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): TOBA (UNKNOWN) | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. BESS KURLANDER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7907 CRISFORD PLA., APT. H BALTO., MD 21208 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOSES MONTEFIORE WOODMOOR HEBREW | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dieter H. Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOGENIC SHOCK | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OLD MYOCARDIAL INFARCTION
ACUTE CHOLECYSTITIS

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|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 X NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D | 29c. LICENSE NUMBER: II 27157 | 29d. DATE SIGNED (Month, Day, Year): 5-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAYNOLD DEFESTRE BALTIMORE COUNTY GENERAL HOSPITAL

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 13209

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mabel Kellum | | | 2. DATE OF DEATH (Month, Day, Year): 5 18 1989 | 3. TIME OF DEATH: 855p M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12 10 99 | 8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): PIKESVILLE CON. NUR. CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: PIKESVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES XX NO |
| 10e. STREET AND NUMBER: 11 WEST 20th ST. | | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY?: US |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BEAUTICIAN | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): RILEY SELLARS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JANE CHAVIS | |
| 19a. INFORMANT'S NAME (Type/Print): LEONARD JOHNSON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1214 N. CHARLES ST. BALTIMORE, MD. 21201 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) XX | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEM. PARK | 20c. LOCATION — City or Town, State: ARBUTUS , MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Loretta Holt #281 | 22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 N. MONROE ST. 21217 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebral Thrombosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic atrial fibrillation
Uric in factor

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|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harold Bob MD | 29c. LICENSE NUMBER: D15872 | 29d. DATE SIGNED (Month, Day, Year): 5/22/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HAROLD BOB MD 7720 Park Height Ave 21208 | | |
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau | |

DHMH-16 Rev 1/89

89 13210

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

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**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie Christine KORPMAN | | 2. DATE OF DEATH (Month, Day, Year): May 23, 1989 | 3. TIME OF DEATH: 3:20 P M |
| 4. SOCIAL SECURITY NUMBER: 215-42-7310 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-4-1900 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore, County | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: ---- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7206 Greenbank Rd. | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): George Frank | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie (Catherine) Knaver | | |
| 19a. INFORMANT'S NAME (Type/Print): Walter W. Korpman LLI | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3202 Brandon Hunt Lane Baldwin Md. 21013 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens Of Faith | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Urosepsis and Cerebral Anoxia. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation e ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Hagan | 29c. LICENSE NUMBER: D37742 | 29d. DATE SIGNED (Month, Day, Year): ▶5-23-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Hagan, M.D. 9000 Franklin Square Dr. Baltimore 21237 | | |
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Gwen Davidson-Landers | |

DHMH-18 Rev 1/89

88 13510

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary Ann KOEHLER | | | 2. DATE OF DEATH (Month, Day, Year): May 25, 1989 | 3. TIME OF DEATH: 6:05 PM |
| 4. SOCIAL SECURITY NUMBER: 219-4--0691 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 47 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-25-47 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

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|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CO. | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5679 LEIDEN ROAD | 10f. ZIP CODE: 21206 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12YEARS; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER | 16b. KIND OF BUSINESS/INDUSTRY: EDUCATION | |
| 17. FATHER'S NAME (First, Middle, Last): EDWARD MATCZUK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISE WAGNER | |
| 19a. INFORMANT'S NAME (Type/Print): MR. H. EDMUND KOEHLER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5679 LEIDEN ROAD BALTIMORE, MARYLAND 21206 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski | 22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTIMORE, MD. 21224 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Brain Carcinoma. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Advanced right breast Carcinoma. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R.S. Miranda MD | 29c. LICENSE NUMBER: D0074 | 29d. DATE SIGNED (Month, Day, Year): 5-25-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Reynaldo Miranda, M.D. 9000 Franklin Square Dr. Baltimore 21237.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): JUN 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 13211

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13212 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CATHERINE M. KEACH
2. DATE OF DEATH (Month, Day, Year): 5 30 89
3. TIME OF DEATH: 9:30 A M
4. SOCIAL SECURITY NUMBER: 213-01-9743
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 9 26 16
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): BALTO. CNTY GEN. HOSP
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Randallstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10408 Liberty Road
10f. ZIP CODE: 21133
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bookkeeper
16b. KIND OF BUSINESS/INDUSTRY: Monumental Life
17. FATHER'S NAME (First, Middle, Last): Charles McGuire
18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Engelhardt
19a. INFORMANT'S NAME (Type/Print): Mr. Roger Keach
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10408 Liberty Road Randallstown, MD 21133
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Memorial Park
20c. LOCATION — City or Town, State: Sykesville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sheila McJenkin
22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE — 2 DAYS
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHRONIC LUNG DISEASE — YEARS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SMALL CELL LUNG CANCER

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: G. I. [illegible] MD
29c. LICENSE NUMBER: D27730
29d. DATE SIGNED (Month, Day, Year): ▶ 5-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY COHEN 711 W. 40TH ST. BALTO MD 21211
31. DATE FILED (Month, Day, Year): JUN 01 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Remmler

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13213
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVA LAND | | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 4 / 89 | 3. TIME OF DEATH: 4:45 AM |
| 4. SOCIAL SECURITY NUMBER: 213-28-9449 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/22/09 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 7909 Crisford Place, | | 10f. ZIP CODE: 21208 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY | | 16b. KIND OF BUSINESS/INDUSTRY: STATE OF MARYLAND | |
| 17. FATHER'S NAME (First, Middle, Last): NATHAN STULMAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA SILBERSTEIN | | | |
| 19a. INFORMANT'S NAME (Type/Print): JERRY LAND | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1117 DORSET DR WEST CHESTER, PA 19382 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PROGRESSIVE RADOMER VEREIN - ROSEDALE, MD | | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joel D Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA, lung — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration Pneumonitis
Atrial Fibrillation

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara Sacha, MD | 29c. LICENSE NUMBER: D35609 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/4/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA SACHA 5401 Old Court Rd. Randallstown, MD | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

88 13513

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13214

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marjorie Stewart Lambdin
2. DATE OF DEATH (Month, Day, Year): 5-8-89
3. TIME OF DEATH: 5:40PM M
4. SOCIAL SECURITY NUMBER: 180-46-7975
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 35 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 12-18-1953
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Loch Raven at Gunpowder Falls
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore County
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3719 Elkader Road Baltimore, Md
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Administrator
16b. KIND OF BUSINESS/INDUSTRY: Nursing care
17. FATHER'S NAME (First, Middle, Last): Philip S. Lambdin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marjorie Rigg
19a. INFORMANT'S NAME (Type/Print): Philip S. Lambdin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1869 Douglas Drive Carlisle, PA 17013
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): East Harrisburg Cem Assoc.
20c. LOCATION — City or Town, State: Harrisburg, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bryan W. Clary — Bryan W. Clary
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld Inc. 10 W. Padonia Road Timonium, Md 21093

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Drowning | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence ☒ Other (Specify) water
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 5-7-89
28b. TIME OF INJURY: 4:40P M
28c. INJURY AT WORK? 1 ☐ YES ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: Subject fell off horse & drowned
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): stream
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Loch Raven at Gunpowder Falls Balto.Co.MD
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 5-9-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 Penn Street, Baltimore, MD 21201 VC
31. DATE FILED (Month, Day, Year): MAY 11 1989
32. REGISTRAR'S SIGNATURE: Julia Pinderhughes-Kendall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13215
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGUERITE M LARRIMORE | | | 2. DATE OF DEATH: MONTH 5 DAY 10 YEAR 89 | 3. TIME OF DEATH: 4:30 PM |
| 4. SOCIAL SECURITY NUMBER: 722-16-1117D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 18, 1895 | 8. BIRTHPLACE (State or Foreign Country): France |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: BALTIMORE |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Stevenson | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1830 Hillside Road | | 10f. ZIP CODE: 21153 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+) | | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking |
| 17. FATHER'S NAME (First, Middle, Last): Francis Aubry | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Adelaide Rosa Logeroh | | |
| 19a. INFORMANT'S NAME (Type/Print): Gabriel Larrimore | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1830 Hillside Rd., Stevenson, Md. 21153 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other): Druid Ridge Cemetery | | 20c. LOCATION — City or Town, State: Pikesville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. J. Eckhardt | | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 21117 11605 Reisterstown RD., Owings Mills, Md. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis DUE TO (OR AS A CONSEQUENCE OF): | 30 hours |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P Cerebral Vascular Accident

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5/10/89 | 28b. TIME OF INJURY: N/A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED: N/A | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Duane Smoot MD | D31831 | ▶ 5/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Duane Smoot MD 7620 York Road Baltimore Md. 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 10 '89 | Julia Davidson-Randall |

DHMH-15 Rev 1/89

88 13512

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13216
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 must be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES COLMAN LINEHAN | | | 2. DATE OF DEATH (Month, Day, Year): May 4, 1989 | 3. TIME OF DEATH: 6:30 A.M |
| 4. SOCIAL SECURITY NUMBER: 213-52-2092 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 27, 1902 | 8. BIRTHPLACE (State or Foreign Country): Cork, Ireland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Martin's Home for the Aged | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 603 Maiden Choice Lane | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 8 yr. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Catholic Priest | 16b. KIND OF BUSINESS/INDUSTRY: Church | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Linehan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Henshon | | |
| 19a. INFORMANT'S NAME (Type/Print): Rev. Jerry Brown, S.S. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5408 Roland Ave. Baltimore, Maryland 21210 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sulpician Cemetery | 20c. LOCATION — City or Town, State: Catonsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Athero-Sclerotic Heart Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Renal Failure, Dementra

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Baskaran | 29c. LICENSE NUMBER: D21649 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-4-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sambandan Baskaran, M.D. 3455 Wilkens Ave. Baltimore, Md. 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13217

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John Alphonsus LEHNER | | | 2. DATE OF DEATH (Month, Day, Year): May 27, 1989 | 3. TIME OF DEATH: 11:00 A M |
| 4. SOCIAL SECURITY NUMBER: 213 07 9046 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 2/18/11 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Balto | 10c. CITY, TOWN OR LOCATION: Rosedale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1109 Chesaco Ave | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY? USA. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White. |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.): Machinist | 16b. KIND OF BUSINESS/INDUSTRY: Machinist | |
| 17. FATHER'S NAME (First, Middle, Last): John Lehner | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Zapf | |
| 19a. INFORMANT'S NAME (Type/Print): Regina M. Lehner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1109 Chesaco Ave Rosedale Md 21237. | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garden of Faith | 20c. LOCATION — City or Town, State: Rossville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: C.A. Hall Rosedale FH. 1211 Chesaco Ave. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adenocarcinoma of Unknown Etiology | 9 mos |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

28d. DESCRIBE HOW INJURY OCCURED

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael Auerbach, MD | 29c. LICENSE NUMBER: D33551 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL AUERBACH, 9000 FRANKLIN Sq. DR. BALTIMORE, MD 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 5/27/89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 13218

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SOPHIE LINDENBERG | | | 2. DATE OF DEATH (Month, Day, Year): 5- 16- 89 | 3. TIME OF DEATH: 4:55 pm M |
| 4. SOCIAL SECURITY NUMBER: 454-48-8641 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/11/01 | 8. BIRTHPLACE (State or Foreign Country): Austria |
| 9a. FACILITY NAME (If not institution, give street and number): Riverview Nursing Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 1 Eastern Boulevard | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker | 16b. KIND OF BUSINESS/INDUSTRY: self | | |
| 17. FATHER'S NAME (First, Middle, Last): Henry Scheitler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise | | | |
| 19a. INFORMANT'S NAME (Type/Print): Richard Lindenberg | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13801 York Road P5/Cockeysville, MD 21030 | | | |
| 20a. METNOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory | 20c. LOCATION — City or Town, State: Silver Spring, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Bradley Funeral Home 2134 Willow Spring Road/Balto. MD 21222 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Alzheimers Disease | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: N/A |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] ATTENDING PHYSICIAN | 29c. LICENSE NUMBER: D29601 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/17/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH B. KUGMAN, MD. / EASTERN BLVD. BALT. MD. 21224 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | | |

DHMH-18 Rev 1/89

89 13219

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Barnett M. Lloyd, Sr. | | | | 2. DATE OF DEATH (Month, Day, Year): 5 16 89 | 3. TIME OF DEATH: 300 A M |
| 4. SOCIAL SECURITY NUMBER: 217343584 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 51 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2/14/38 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: 21207 |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTO. | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3304 Ripple Road | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: United State |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 0+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: Amtrak |
| 17. FATHER'S NAME (First, Middle, Last): Charles James Lloyd, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Adams |
| 19a. INFORMANT'S NAME (Type/Print): Dosezell Scott | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3304 Ripple Rd. Balto., Md. 21207 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem. | 20c. LOCATION — City or Town, State: Owings Mills, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dola March | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. AIDS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bonnie S Rosen, MD | 29c. LICENSE NUMBER: 065-58-4373 | 29d. DATE SIGNED (Month, Day, Year): 5/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bonnie S. Rosen, MD 2801 Baneberry Ct, Baltimore, MD 21209

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dundon-Lindsay |

DHMH-15 Rev 1/89

89 13220

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Hellen L. Larsen | | | 2. DATE OF DEATH: MONTH 5 DAY 13 YEAR 1989 | 3. TIME OF DEATH: 1:30 AM |
| 4. SOCIAL SECURITY NUMBER: 214-01-6934A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-17-1908 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6604 Alta Ave. | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Packing Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Frank Hockaday | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsa ------ | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Karl N. Larsen | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6604 Alta Ave. Balto., Md. 21206 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hartley Miller | | 22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease — years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURRED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D13272 | 29d. DATE SIGNED (Month, Day, Year): 5-15-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 120 Sr. Pierre Dr. Ste. 506 Towson MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

88 13550

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13221
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna C. Lane
2. DATE OF DEATH (Month, Day, Year): 5-14-1989
3. TIME OF DEATH: 3:15 AM
4. SOCIAL SECURITY NUMBER: 217-38-0688D
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-23-1902
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Josephs Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: ----
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2107 Townhill Rd. Apt. C
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—ti yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+): 2 yrs.
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Henry P. Hoffman
18. MOTNER'S NAME (First, Middle, Maiden Surname): Mathilde Herghenroter
19a. INFORMANT'S NAME (Type/Print): Mrs. Audrey A. Nollert
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2701 Sarah Lane. Balto., Md. 21234
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore National Cemetery
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Hartley Miller
22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md 21234

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RHABDOMYOLysis
DUE TO (OR AS A CONSEQUENCE OF):
b. ELECTROLYTE IMBALANCE.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ceballos, M.D.
29c. LICENSE NUMBER: D 25886
29d. DATE SIGNED (Month, Day, Year): ▶ 5/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CEBALLOS, M.D. - ST. JOSEPH HOSPITAL - TOWSON, MD 21204
31. DATE FILED (Month, Day, Year): MAY 15 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13222

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY E.LOVELL | | | | 2. DATE OF OEATH: MONTH 05 DAY 07 YEAR 89 | 3. TIME OF DEATH: 220 A M |
| 4. SOCIAL SECURITY NUMBER: 216-66-9795 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 074 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 06 18 14 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CTR | | | 9b. CITY, TOWN OR LOCATION OF OEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: LUTHERVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 113 SEMINARY AVE , West | | 10f. ZIP CODE: 21093 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+) | | 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking |
| 17. FATHER'S NAME (First, Middle, Last): John Oscar Beares | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Jones | |
| 19a. INFORMANT'S NAME (Type/Print): Mary K. Alban | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Bromley Ct, Timonium, Md. 21093 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF OISPOSITION (Name of cemetery, crematory or other place): Weisburg Cemetery | 20c. LOCATION — City or Town, State: White Hall, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bryan W. Clary | | 22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md.21093 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory srrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CEREBRAL HYPOXIA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leeding to immedlete ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CARDIORESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
c. METASTATIC CANCER, CHF, BULBAR PALSY
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. OESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Danny Lowe | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/7/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print): DANNY LOWE JR, MD | | 6701 N CHARLES ST, TOWSON MD 21204 |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

30

DHMH-18 Rev 1/89

89 13223

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): KATRINA LYNN LOCKNER | | | | 2. DATE OF DEATH (Month, Day, Year): 05 01 89 | 3. TIME OF DEATH: 1 10 PM |
| 4. SOCIAL SECURITY NUMBER: 219-21-6806 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 9 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov. 16, 1979 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 17 Pendragon Court | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Reisterstown | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 17 Pendragon Court | | 10f. ZIP CODE: 21136 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | | 16b. KIND OF BUSINESS/INDUSTRY: ---- | |
| 17. FATHER'S NAME (First, Middle, Last): Kevin Blair Lockner | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sherry G. Carr | | |
| 19a. INFORMANT'S NAME (Type/Print): Kevin B. Lockner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Pendragon Court, Reisterstown, Md. 21136 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem. | | 20c. LOCATION — City or Town, State: Owings Mills, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. Eckhardt | | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 21117, 11605 Reisterstown Rd., Owings Mills, Md. | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute myeloid leukemia | 5 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Relapsed acute lymphocytic leukemia | 20 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Heterotopania

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Donald Small M.D., P.A. | D35467 | ▶ 5/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald Small M.Sc. 800-Pediatric oncology — 600 N. Wolfe St. Balt., Md. 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 5 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13224

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BLANCHE A. LEISEY | | 2. DATE OF DEATH (Month, Day, Year): 5-6-1989 | 3. TIME OF DEATH: 11:35 P.M |
| 4. SOCIAL SECURITY NUMBER: 217-36-4260 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-27-1911 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 15024 Wheeler La. | 9b. CITY, TOWN OR LOCATION OF DEATH: Priceville | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford, | 10c. CITY, TOWN OR LOCATION: Kingsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 706 Pleasant Hills Cir. | 10f. ZIP CODE: 21087 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Herbert F. McCaffrey | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Marie Giles | | |
| 19a. INFORMANT'S NAME (Type/Print): Charles R. Brownley | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 706 Pleasant Hills Cir., Kingsville, Md. 21087 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cem. 5-9-89 | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather / Roy H. Cather | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute CHF — DUE TO (OR AS A CONSEQUENCE OF): Hypertensive

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. [illegible] — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] M.D. | 29c. LICENSE NUMBER: D08358 | 29d. DATE SIGNED (Month, Day, Year): 5/8/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gracito Patricio, M.D., 8903 Harford Rd., Balto., Md. 21234 | | |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13225 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DONSEY LEE | | | | | 2. DATE OF DEATH (Month, Day, Year): 4/12/89 | | 3. TIME OF DEATH: 5:33 P M |
| 4. SOCIAL SECURITY NUMBER: 213-12-2512 | 5. SEX: M 2 F | 6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-11-08 | | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Homewood Hospital Center South | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | | 9c. COUNTY OF DEATH: Baltimore County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1519 N, Miljton Ave. | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: usa |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautician | 16b. KIND OF BUSINESS/INDUSTRY: Cosmetology | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Johnson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Louvinia Johnson | |
| 19a. INFORMANT'S NAME (Type/Print): Annie L., Johnson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1519 N. Milton Ave. Balto. Md. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. National Mem. Pk. | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Carlton C. Douglass | | 22. NAME AND ADDRESS OF FACILITY: 1701 McCulloh St,. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Extensive Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Bleeding Gastric ulcer

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Human Medicine MD | 29c. LICENSE NUMBER: D15698 | 29d. DATE SIGNED (Month, Day, Year): 4/12/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARCOS GALICIA M.D. Homewood Hospital Center, South | | |
| 31. DATE FILED (Month, Day, Year): APR 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dendon-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13226

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page ... contained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ... should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Clara R. LaBanz LaBanz | | | 2. DATE OF DEATH: MONTH 5 DAY 23 YEAR 89 | 3. TIME OF DEATH: 4:30 AM |
| 4. SOCIAL SECURITY NUMBER: 213-20-7757 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 26, 1896 | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): ST Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE Towson | | 9c. COUNTY OF DEATH: Baltimore Co. County |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Parkville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 8205 Laurel Dr. | | 10f. ZIP CODE: 21234 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Juchs | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Budnick | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Rita E. Guzzone | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8205 Laurel Dr. Baltimore, Maryland 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral 5/25/89 | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock Jr | | 22. NAME AND ADDRESS OF FACILITY: Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic Heart Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Upper GI Bleed

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ethan Spiegler MD | D34502 | ▶ 5-23-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ETHAN SPIEGLER MD ST JOSEPH HOSPITAL

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | Julia Davidson-Rudasa |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13227
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Mabel B. Longfellow | | 5 / 15 / 89 | 5:51 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 221-14-4026 | 1 ☐ M 2 ☒ F | 91 YRS. | | | 11/7/1897 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Augsburg Lutheran Home | Baltimore | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Baltimore | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Augsburg Lutheran Home 6811 Campfield Rd. | 21207 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8th Grade | | Nursing Assistant | City Hospital |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Walter Stansbury | Unknown Schanger |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Augsburg Lutheran Home | 6811 Campfield Rd.. Baltimore, MD 21207 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Moreland Memorial Park | Parkville , MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ John K Agnew | Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBRAL THROMBOSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- SEIZURE DISORDER
- HYPERPARATHYROIDISM
- MULTIINFARCT DEMENTIA

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Jasmeen Lalwani | D28595 | ▶ 5/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
7220 PARK HEIGHTS AVE, BALTO MD 21208

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | |

DHMH-18 Rev 1/89

89 13227

Unknown 89-70

89 13228

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anthony Mack Lawton | | | 2. DATE OF DEATH (Month, Day, Year): 5 / 25 / 89 | 3. TIME OF DEATH: 4:50 p M |
| 4. SOCIAL SECURITY NUMBER: 072-58-5920 | 5. SEX: 1 [X] M 2 [ ] F | 8. AGE (In yrs. last birthday): 18 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Oct.16,1970 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): 5200 Eastbury Avenue #C | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Virginia | 10b. COUNTY: Prince William | 10c. CITY, TOWN OR LOCATION: Woodbridge | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3548 Forestdale Avenue | | 10f. ZIP CODE: 22193 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unemployed | 16b. KIND OF BUSINESS/INDUSTRY: None | |
| 17. FATHER'S NAME (First, Middle, Last): Howard Lawton | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EDNA WORTHY | |
| 19a. INFORMANT'S NAME (Type/Print): Edna Collins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3548 Forestdale Avenue, Woodbridge, Va. 22193 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Coleman Cemetery | 20c. LOCATION — City or Town, State: Alexandria, Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard O. Ames | | 22. NAME AND ADDRESS OF FACILITY: Ames Funeral Home, 8914 Quarry Rd., Manassas, Va.22110 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute narcotic intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5/25/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Balto., Md. 5200 Eastbury Avenue #C |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 5/26/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 23 (Type, Print): Julia C. Goodin, M.D., 111 Penn Street, Baltimore, Maryland 21201 | | |
| 31. DATE FILED (Month, Day, Year): MAY 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Tandoh | |

DHMH-16 Rev 1/89

88 13558

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13229

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frank Patenall Litz, Sr. | | | | | 2. DATE OF DEATH (Month, Day, Year): 5 28 89 | 3. TIME OF DEATH: 7:15 p.m. |
| 4. SOCIAL SECURITY NUMBER: 218-32-1234 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-13-10 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 245 Ridge Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | | 9c. COUNTY OF DEATH: Baltimore Co. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore Co. | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 245 Ridge Ave. | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): self-employed | 16b. KIND OF BUSINESS/INDUSTRY: dry cleaning/laundry | |
| 17. FATHER'S NAME (First, Middle, Last): Henry George Litz | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Loretta Alfonsa Foige | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Catherine Litz | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 245 Ridge Ave. Towson, Md. 21204 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John E Reitz | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiopulmonary arrest | Imm. |
| DUE TO (OR AS A CONSEQUENCE OF): | b. arteriosclerotic heart disease | several years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. hypertension | |
| | d. Renal failure | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: E D Salem | 29c. LICENSE NUMBER: D25686 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EBRAHIM IPAKCHI MD. 7401 OSLER DRIVE BALTIMORE MD 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): JUN 01 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

Item 29d Per F.H. and R.B. Filmg652 6/13/89 CG

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13230 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH T. MENGERS | | | | | 2. DATE OF DEATH (Month, Day, Year): 05/12/1989 | 3. TIME OF DEATH: 4:10 p M | |
| 4. SOCIAL SECURITY NUMBER: 216-46-2605 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 02/24/1907 | 8. BIRTHPLACE (State or Foreign Country): Md. | |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: Lutherville | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | | |
| 10e. STREET AND NUMBER: 1413 TENBURY ROAD, LUTHERVILLE | | 10f. ZIP CODE: 21093 | | | 10g. CITIZEN OF WHAT COUNTRY: USA | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): C. M. Tickner | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Miller | | |
| 19a. INFORMANT'S NAME (Type/Print): Frederick W. Mengers, Jr. | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1413 Tenbury Road Lutherville, Md. 21093 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery | | | 20c. LOCATION — City or Town, State: Baltimore, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Nathan Kaney Jr | | | | | 22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADULT RESPIRATORY DISTRESS SYNDROME | #3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Morland A Stettnisch | | ▶ 6/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
6701 NORTH CHARLES ST. TOWSON, MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 19 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13231
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Macneal, AKA: HELEN M. MACNEAL, Helen
2. DATE OF DEATH — MONTH: 5 DAY: 4 YEAR: 89
3. TIME OF DEATH: 2:27 A M
4. SOCIAL SECURITY NUMBER: 219-16-8786
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/20/1902
8. BIRTHPLACE (State or Foreign Country): Md
8a. FACILITY NAME (If not institution, give street and number): Perring Pkwy Meadow Nursing Centr
9b. CITY, TOWN OR LOCATION OF DEATH: Parkville
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Rosedale
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1326 Evering Ave.
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: CAU. White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): James Tracy
16. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Moran
19a. INFORMANT'S NAME (Type/Print): James Macneal, Sr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5404 Ready Ave., Baltimore, MD 21212
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Green Mount Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Gray Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Ischemic Heart disease — years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hypertension — DUE TO (OR AS A CONSEQUENCE OF):

c. Diabetes — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Milton Reid M.D.
29c. LICENSE NUMBER: D 028358
29d. DATE SIGNED (Month, Day, Year): ▶ 5/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patrick G. Patrick M.D.
31. DATE FILED (Month, Day, Year): MAY 1 - 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

88 13531

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13232 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, [illegible], MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. It may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Oliver Mason, Jr. | | | | | 2. DATE OF DEATH (Month, Day, Year): May 04, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-03-2342 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 08/05/17 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 57 Randall Avenue | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lansdowne | | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Md | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 310 S. Calhoun Street | | 10f. ZIP CODE: 21223 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1941-1946 | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: no | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): -------- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor | | | 16b. KIND OF BUSINESS/INDUSTRY: Gov't. | |
| 17. FATHER'S NAME (First, Middle, Last): Oliver Mason, Sr. | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Eber | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Linda Mason | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 57 Randall Avenue Lansdowne Md 21227 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | | | 20c. LOCATION — City or Town, State: Baltimore City, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | | | | 22. NAME AND ADDRESS OF FACILITY: AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD, ARBUTUS, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Recurrent Lung Cancer (Non Small Cell) | 2 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Wm C Waterfield MD | 024356 | ▶ 5/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W. C. Waterfield, [illegible] Hospital 900 Caton Ave Balt Md 21229

| 31. DATE RECEIVED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 8 - 1989 | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13233
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death occurs. Page 4 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from State.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GASPAR MARINO | | | 2. DATE OF DEATH (Month, Day, Year): 5 - 1 - 1989 | 3. TIME OF DEATH: 12:30 PM |
| 4. SOCIAL SECURITY NUMBER: 215-05-1944 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JAN. 10, 1908 | 8. BIRTHPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: OWINGS MILLS | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 51 S. TOLLGATE ROAD | | 10f. ZIP CODE: 21117 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 1 YEAR | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN | 16b. KIND OF BUSINESS/INDUSTRY: TONY VITRANO COMPANY |
| 17. FATHER'S NAME (First, Middle, Last): NOT KNOWN MARINO | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIA NOT KNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): KATE BASKETTE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 51 S. TOLLGATE ROAD OWINGS MILLS, MD 21117 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLLY HILL MEMORIAL MAY 4, 1989 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thos W. Fisher | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | |

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | e. Acute Myocardial Infarction. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cancer of the Colon

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Allan J. Chiocca M.D. | 29c. LICENSE NUMBER: D29085 | 29d. DATE SIGNED (Month, Day, Year): 5-1-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allan J. Chiocca M.D. Baltimore County General Hospital | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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item 16a & 16b 5-23-89 film G651
W.H. Per f/h

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13234 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. ... signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral ... page 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAYMOND K. MILES, SR | | | | 2. DATE OF DEATH (Month, Day, Year): 5 5 89 | 3. TIME OF DEATH: 11:56 AM |
| 4. SOCIAL SECURITY NUMBER: 219-30-2911 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12 26 1899 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE CO. GEN. HOSP. | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: CARROLL | 10c. CITY, TOWN OR LOCATION: SYKESVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6743 MARVIN AVE | 10f. ZIP CODE: 21784 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ~~BANK GUARD~~ Policeman | 16b. KIND OF BUSINESS/INDUSTRY: ~~Balto City~~ ~~MARYLAND NATIONAL~~ | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES WESLEY MILES | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA MARIE LOOSE | |
| 19a. INFORMANT'S NAME (Type/Print): CAROLYN MILES | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6743 MARVIN AVE SYKESVILLE, MD. 21784 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight | | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME BOX 195 SYKESVILLE MD 21784 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic Pancreatic Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick A Turner MD | 29c. LICENSE NUMBER: D20806 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PATRICK A. TURNER, MD 1425 Liberty Road Eldersburg, Md | | |
| 31. DATE FILED (Month, Day, Year): MAY 8 - 1989 | 32. REGISTRAR'S SIGNATURE: Julia Trieber Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13235

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Hilda D. McClung | | | | | 2. DATE OF DEATH (Month, Day, Year): 5 16 1989 | 3. TIME OF DEATH: A M |
| 4. SOCIAL SECURITY NUMBER: 233-34-7262 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1 31 1920 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): 3143 Sollers Pt.Rd. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk | | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | | 10c. CITY, TOWN OR LOCATION: Dundalk, Md. | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3143 Sollers Point Rd. | | | 10f. ZIP CODE: 21222 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Wire & Cords | | | 16b. KIND OF BUSINESS/INDUSTRY: Western Electric |
| 17. FATHER'S NAME (First, Middle, Last): Cornelius W. Dorsey | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Humphreys | | | |
| 19a. INFORMANT'S NAME (Type/Print): June C. Dayhoff | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 E.Green St. Westminster,Md. 21157 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | | | 20c. LOCATION — City or Town, State: Rossville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home 2134 Willow Spring Rd. Dundalk, Md. | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sudden Cowdin Death. | Immediate |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Obstructive Pulmonary Disease | 10 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Atrial Arrhythmia. | 10 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Chron Athsm. | 20 yrs |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD. | D30555 | ▶ 5/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan N. Dennis 7120 North Point Rd. Balto, Md 21219

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 19 1989 | [signature] |

DHMH-16 Rev 1/89

88 13532

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13236 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary B. McCray | | | 2. DATE OF DEATH: MONTH 5 DAY 25 YEAR 89 | 3. TIME OF DEATH: 10:35 A M |
| 4. SOCIAL SECURITY NUMBER: 242-03-7750 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/20/20 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): University of Maryland Hospital ER | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Maryland | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Balto. | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3008 Mondawin Avenue | | 10f. ZIP CODE: 21216 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): District Court | | 16b. KIND OF BUSINESS/INDUSTRY: State of Md. |
| 17. FATHER'S NAME (First, Middle, Last): Chairman Aron Barnes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ophelia Willowby | | |
| 19a. INFORMANT'S NAME (Type/Print): Steven McCray | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3008 Mondawin Avenue, Balto., Md. 21216 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet Cem | | 20c. LOCATION — City or Town, State: Owings Mills, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave. | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Known "heart condition" per Medic Alert band
Diabetes mellitus treated with insulin

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) University of Maryland Hosp ER

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|
| 5/25/89 | ~ 9:15AM | 1 ☐ YES 2 ☒ NO | Uncertain causes, sudden arrest |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Golf course

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Scott M. Hamilton, M.D. | | ▶ 5/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Scott M. Hamilton, M.D.

| 31. DATE RECEIVED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 5/25/89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13237
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Amanda AKA: Anna Amanda Mackey MACKEY | | | 2. DATE OF DEATH (Month, Day, Year): May 14 1989 | 3. TIME OF DEATH: 6:22 a.m. |
| 4. SOCIAL SECURITY NUMBER: 212-26-9145A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 14, 1898 | 8. BIRTHPLACE (State or Foreign Country): Finland |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: -- | | 9c. COUNTY OF DEATH: BALTIMORE COUNTY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: WHITE MARSH | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5401 FORGE ROAD | 10f. ZIP CODE: 21162 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JACOB VIITASALO | 16. MOTHER'S NAME (First, Middle, Maiden Surname): MARY HONKOLA | | |
| 19a. INFORMANT'S NAME (Type/Print): IRENE KOLSTROM - SISTER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5401 Forge Road, White Marsh, Md. 21162 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process | 20c. LOCATION — City or Town, State: Balto, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME 9705 Belair Road, Balto, Md. 21236 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypotension,
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cardiac Dysrrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
c. Acute Renal Failure
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Malnutrition

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 5/14/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jan Bachowski, M.D. 9000 Franklin Square Drive, 21237 | | |
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

DNMH-16 Rev 1/89

68 13531

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13238

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA MARQUESS | | | 2. DATE OF DEATH (Month, Day, Year): 05 17 89 | 3. TIME OF DEATH: 8 10 PM |
| 4. SOCIAL SECURITY NUMBER: 219-03-6670 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01-30-18 | 8. BIRTHPLACE (State or Foreign Country): NEW JERSEY |
| 9a. FACILITY NAME (If not institution, give street and number): ST JOSEPHS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5908 ROLAND AVENUE | | 10f. ZIP CODE: 21210 | 10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 8+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Bertram Gillette | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Sargent | |
| 19a. INFORMANT'S NAME (Type/Print): William H. Marquess, III | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5908 Roland Ave. 21210 Balto. Md. | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Kratz ▶ Robert M. Kratz | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. Balto. Md. 21212 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Extension of acute lateral wall subendocardial MI | > 1 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary Artery Disease | 3 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Breast cancer s/p R mastectomy
Osteoarthritis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Gary A Manko | 29c. LICENSE NUMBER: D25062 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY A. MANKO MD, 11 E Chestnut Hill Ln, Reisterstown, MD 21136

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Pleasants-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13239 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH R. MOREFOOT
2. DATE OF DEATH (Month, Day, Year): 05 06 1989
3. TIME OF DEATH: 5:00 pM
4. SOCIAL SECURITY NUMBER: 215-01-6560
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/12/1902
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 609 HARDING PLACE, BALTIMORE
10f. ZIP CODE: 21211
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YRS. — College (1-4 or 5+): 2 YRS
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): WINFRED ANDERSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARTHA RICHARDSON
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY
20c. LOCATION — City or Town, State: BALTO., MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Parker T. Evans, Jr.
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. BREAST CANCER
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: X Robert D'Amato MD/PhD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ X 5/6/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): X Robert D'Amato 6701 NORTH CHARLES ST, TOWSON, MD 21204
31. DATE FILED (Month, Day, Year): MAY 11 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Landeck

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13240 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Shirley Jean Marshall
2. DATE OF DEATH (Month, Day, Year): May 4, 1989
3. TIME OF DEATH: 8:30 AM
4. SOCIAL SECURITY NUMBER: 219-32-5418
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 52 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 9, 1936
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 25 Lastgate Road
9b. CITY, TOWN OR LOCATION OF DEATH: Owings Mills
9c. COUNTY OF DEATH: Baltimore

**RESIDENCE OF DECEDENT**

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Owings Mills
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 25 Lastgate Road
10f. ZIP CODE: 21117
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Rockland, Inc.
17. FATHER'S NAME (First, Middle, Last): John Franklin Williams
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys Keeney
19a. INFORMANT'S NAME (Type/Print): Kelly Marshall
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 Lastgate Rd., Owings Mills, Md. 21117
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery
20c. LOCATION — City or Town, State: Woodlawn, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. Eckhardt
22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of Colon | 1983 |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Donald J. Mull M.D.
29c. LICENSE NUMBER: D06980
29d. DATE SIGNED (Month, Day, Year): ▶ 5-5-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David J. M.[illegible] - 10519 S. Lastgate Rd Owings Mills, Md 21117
31. DATE FILED (Month, Day, Year): MAY 5 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13241

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

5

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE EDWARD MILLER
2. DATE OF DEATH (Month, Day, Year): 5 2 89
3. TIME OF DEATH: 10:30 PM
4. SOCIAL SECURITY NUMBER: 215-09-4241
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/1/1897
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Towson MD 21204
9c. COUNTY OF DEATH: BALTO.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Jarrettsville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3721 Old Federal Hill Road
10f. ZIP CODE: 21084
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: World War I
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Repairman
16b. KIND OF BUSINESS/INDUSTRY: Refridgeration
17. FATHER'S NAME (First, Middle, Last): Alpheus Caldwell Miller
18. MOTHER'S NAME (First, Middle, Maiden Surname): Araminta Minerva Morrison
19a. INFORMANT'S NAME (Type/Print): Hildegarde Miller
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Bel Air Mem. Gardens
20c. LOCATION — City or Town, State: Bel Air, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Gladden Kurtz
22. NAME AND ADDRESS OF FACILITY: Kurtz Funeral Home, Jarrettsville, Maryland 21084

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease — years

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D13272
29d. DATE SIGNED (Month, Day, Year): ▶ 5-3-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert E. Stoner MD Suite 206 1210 Sister Pierre Dr. Towson MD 21204
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Sandoval

DHMH-16 Rev 1/89

ITEM#6 FILM# G651 5/8/89 JA /PER F. H.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13242 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY A. MACE-CHILCOAT | | 2. DATE OF DEATH (Month, Day, Year): May 5, 1989 | 3. TIME OF DEATH: 3:30 A M |
| 4. SOCIAL SECURITY NUMBER: 095-14-4217 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): ~~65~~ 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 21, 1924 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 6611 Raven Hill Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | 9c. COUNTY OF DEATH: Baltimore County | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore County | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6611 Raven Hill Road | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): ---------- | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant | 16b. KIND OF BUSINESS/INDUSTRY: Accounting | |
| 17. FATHER'S NAME (First, Middle, Last): Arsene Cyr | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alida DuBoise | | |
| 19a. INFORMANT'S NAME (Type/Print): Robert L. Chilcoat | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15007 LaVale Road Monkton, Maryland21111 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore National Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William E. Johnson | 22. NAME AND ADDRESS OF FACILITY: William E. Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | METASTATIC CANCER to LUNGS | 4 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | METASTATIC CANCER RIGHT BASE OF SKULL | 7 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | SQUAMOUS CELL CARCINOMA RIGHT BASE OF TONGUE | 8 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John W. Jamison MD | D28133 | 5-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1001 Cromwell Bridge Road Baltimore Md 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 5 1989 | Julia Davidson Deputy |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13243 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPHINE MARKELL
2. DATE OF DEATH (Month, Day, Year): 5 2 89
3. TIME OF DEATH: 12;26P.M. M
4. SOCIAL SECURITY NUMBER: 123-03-8825
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/29/04
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Essex
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 140 Lariat Road
10f. ZIP CODE: 21220
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Rep.
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Abraham Gitler
18. MOTHER'S NAME (First, Middle, Maiden Surname): Besse Barshad
19a. INFORMANT'S NAME (Type/Print): Donald Markell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 140 Lariat Road Baltimore, Md. 21220
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process Crematory
20c. LOCATION — City or Town, State: Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lewis P. Smith
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO - PULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ACUTE MYOCARDIAL INFARCTION

DUE TO (OR AS A CONSEQUENCE OF):

c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Teodulo Paglinauan Jr MD
29c. LICENSE NUMBER: D15022
29d. DATE SIGNED (Month, Day, Year): ▶ 5-02-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Teodulo Paglinauan 8552 Philadelphia Road
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13244

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bessie Perl Marlow | | | 2. DATE OF DEATH (Month, Day, Year): May 4, 1989 | 3. TIME OF DEATH: 12:05 PM M |
| 4. SOCIAL SECURITY NUMBER: 212-09-8754D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 96 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 02/08/93 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 86 Mellor Avenue | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): John William Sheppard | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Gover | | |
| 19a. INFORMANT'S NAME (Type/Print): Ella B. Hoffman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 86 Mellor Avenue Catonsville, MD 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State: Elkridge, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Geo. E. MacNabb | | 22. NAME AND ADDRESS OF FACILITY: MacNabb Funeral Home 301 Frederick Road Balto., MD 21228 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CVA | 1yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Philip H Konits | D24321 | ▶ May 5, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Philip H. Konits, M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 8 - 1989 | Julia Davidson-Brand, RR |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13245

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Robert Burrell Marr

**2. DATE OF DEATH** (Month, Day, Year): May 21 1989

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 216-07-4958

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 78 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Nov. 12 1910

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): Meridian Nursing Home, Perring Pkwy.

**9b. CITY, TOWN OR LOCATION OF DEATH**: Parkville

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Parkville

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 1801 Wentworth Road

**10f. ZIP CODE**: 21234

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW II

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Book Binder

**16b. KIND OF BUSINESS/INDUSTRY**: Bindery & Check Printing Co.

**17. FATHER'S NAME** (First, Middle, Last): Robert E. L. Marr

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Anne B. Rixham

**19a. INFORMANT'S NAME** (Type/Print): Betty Marr

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Gorsuch Road, Timonium, Md. 21093

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Gardens of Faith

**20c. LOCATION — City or Town, State**: Rossville, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Bryan W. Clary

**22. NAME AND ADDRESS OF FACILITY**: Lemmon-Mitchell-Wiedefeld
10 W. Padonia Road, Timonium, Md. 21093

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | PNEUMONIA | 1 month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PARKINSON'S DISEASE | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature]

**29c. LICENSE NUMBER**: D20673

**29d. DATE SIGNED** (Month, Day, Year): 5/22/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): George Lowe, M.D. 3703 Belair Road, Balto., Md.

**31. DATE FILED** (Month, Day, Year): MAY 24 1989

**32. REGISTRAR'S SIGNATURE**: [signature]

6 +1

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13246
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELEANOR ANNE MATTHEWS | | | | 2. DATE OF DEATH (Month, Day, Year): 05 06 1989 | 3. TIME OF DEATH: 12:30 A. M |
| 4. SOCIAL SECURITY NUMBER: 213-38-5244 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 05/03/99 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): G.B.M.C. 6701 N. CHARLES ST | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD 21204 | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | | |
|---|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: ~~BALTIMORE~~ Cockeysville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: ~~703 CEDARCROFT RD~~ 13801 York Rd. | | 10f. ZIP CODE: ~~21212~~ 21030 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 years | |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher | | 16b. KIND OF BUSINESS/INDUSTRY: Education |
| 17. FATHER'S NAME (First, Middle, Last): ELI A MATTHEWS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ORRICK |
| 19a. INFORMANT'S NAME (Type/Print): David Matthews | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 703 Cedarcroft Rd. Baltimore, Md. 21212 |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Friends Gunpowder Cemetery | 20c. LOCATION — City or Town, State: Sparks, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John D Reich | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPTIC SHOCK | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PERFORATED DIVERTICULITIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIAC ARRHYTHMIAS

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R Breitenecker MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/6/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): R. BREITENECKER M.D. 6701 N. CHARLES ST, BALTIMORE, MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: John Davidson-Registrar | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13247
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached because as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lena Michetti | | | 2. DATE OF DEATH (Month, Day, Year): May 22, 1989 | 3. TIME OF DEATH: 6:30 P M |
| 4. SOCIAL SECURITY NUMBER: 213-74-5411 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 27, 1893 | 8. BIRTHPLACE (State or Foreign Country): Italy |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson - MD | | 9c. COUNTY OF DEATH: Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER: 6905 Donachie Road | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Anthony Lombardi | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alvigi | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Daniel J. Michetti | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6905 Donachie Road Baltimore, Maryland 21239 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial 5/25/89 | 20c. LOCATION — City or Town, State: Cockeysville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James J. Gladden | | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck Inc. 5305 Harford Road 21214 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Possible myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. bleeding diverticulosis, Renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. pneumonia | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Pemy Chhim | 29c. LICENSE NUMBER: Dr 6954 | 29d. DATE SIGNED (Month, Day, Year): ▶ 05/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PEMY CHHIM

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13248

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARRY L. MILLER JR. | | | 2. DATE OF DEATH (Month, Day, Year): 05 22 89 | 3. TIME OF DEATH: 7:25 P. M |
| 4. SOCIAL SECURITY NUMBER: 212-05-4092 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04/26/09 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): 211 NEWBURG AVENUE | | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: COLUMBIA | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 9401 DIAMONDBACK DRIVE | | 10f. ZIP CODE: 21045 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICAL ENGINEER | 16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE GAS & ELECTRIC | | |
| 17. FATHER'S NAME (First, Middle, Last): HARRY L. MILLER SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY LOUISE OETERS | | |
| 19a. INFORMANT'S NAME (Type/Print): BETH HOLTZ | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1435 FOREST PARK AVENUE BALTIMORE, MD 21207 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CREST LAWN CEMETERY | 20c. LOCATION — City or Town, State: MARRIOTTSVILLE, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lawrence Witzke | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Congestive Heart Failure | 2 month |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | atherosclerotic Cardiovascular disease | > 5 years. |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] Paul MD | D-18089 | 5/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEVEN M POLLAK MD. 7525 GREENWAY CTR, Greenbelt Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | Julia Davidson-Lindsay |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13249
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MULLINS, DREWIE | | | 2. DATE OF DEATH (Month, Day, Year): 5 26 89 | 3. TIME OF DEATH: 7.50 PM |
| 4. SOCIAL SECURITY NUMBER: 212-26-5013 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/22/06 | 8. BIRTHPLACE (State or Foreign Country): USA |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSP. | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTO |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: CARROLL (Carroll) | 10c. CITY, TOWN OR LOCATION: WESTMINSTER | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 314 CHURCH ST. | | 10f. ZIP CODE: 21157 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | | 14. RACE — Amaricen Indien, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker | 16b. KIND OF BUSINESS/INDUSTRY: Construction | | |
| 17. FATHER'S NAME (First, Middle, Last): Lathe Mullins | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eliza ? | | |
| 19a. INFORMANT'S NAME (Type/Print): Lawrence Mullins | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4717 Old Washington Road Sykesville, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Burdine Cemetery | 20c. LOCATION — City or Town, State: Sneedville, Tennessee | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian Luther Haight | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) SYKESVILLE, MARYLAND 21784 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a) METABOLIC ACIDOSIS ? II° to MESENTERIC ISCHAEMIA | |
| | b. ACUTE RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. COAL MINERS LUNG DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CONGESTIVE CARDIAL FAILURE OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☑ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCUREO | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIONED (Month, Day, Year) |
|---|---|---|
| Ram Nimmagadda | BD 36612 | ▶ 5/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAM NIMMAGADDA, BCGH, 5401 OLD CT. Rd., RANDALLSTOWN MD 21133

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Landeau |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13250

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FITZHUGH LEE MARTIN | | | 2. DATE OF DEATH (Month, Day, Year): 05 30 89 | 3. TIME OF DEATH: 11:41 AM |
| 4. SOCIAL SECURITY NUMBER: 229-05-2500 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07/16/05 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Cockeysville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 300 International Circle | | 10f. ZIP CODE: 21030 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Telephone Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Fitzhugh Lee Martin, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Garrett | |
| 19a. INFORMANT'S NAME (Type/Print): Maryland MAsonic Homes | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 International Circle, Cockeysville, Md. 21030 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Liberty Baptist Cemetery | 20c. LOCATION — City or Town, State: Appomattox, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Burnside, Jr. | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL INSUFFICIENCY

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: X [illegible] | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NICHOLAS P. GEORGES, M.D. G.B.M.C. DEPT. OF INT. MEDICINE TOWSON 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): JUN 01 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 13520

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13251

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERNARD JOSEPH DeSALES McGARVEY | | | | | 2. DATE OF DEATH: MONTH 5 DAY 28 YEAR 89 | 3. TIME OF DEATH: 8:25P M |
| 4. SOCIAL SECURITY NUMBER: 217-14-1895 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-21-17 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 1319 Glenmont Rd. 21239 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | | |
|---|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 1319 Glenmont Rd. | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | Sales Manager | Petroleum |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Frank P. McGarvey | Jennie McNicholas |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Edna R. McGarvey | 1319 Glenmont Road Baltimore, Maryland 21239 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Dulaney Valley | Lutherville, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Dennis Stephen Xenakis | Mitchell-Wiedefeld 6500 York Rd 21212 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARCINOMA OF PROSTATE WITH BONEY METASTASES | 14 MO. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CARCINOMA OF LUNG - LARGE WITH VASCULAR INVASION | 14 MO. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. PERIPHERAL VASCULAR DISEASE WITH RECENT THROMBOSIS R LEG | 7 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS, CHRONIC ANEMIA, B12 MALABSORPTION

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John A. Nesbitt III MD attending Physician | | ▶ 5-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN A. NESBITT, III MD 201 E. UNIVERSITY PKWY. BALT., MD. 21218

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| JUN 01 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 13521

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13252

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BETTY JANE MULLINIX | | | 2. DATE OF DEATH (Month, Day, Year): 5-18-89 | 3. TIME OF DEATH: 11:45 M |
| 4. SOCIAL SECURITY NUMBER: 218-24-7554 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-20-29 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gneral Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Sykesville | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7719 Carter Road | | 10f. ZIP CODE: 21784 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk-Typist | 16b. KIND OF BUSINESS/INDUSTRY: Vitro Company | |
| 17. FATHER'S NAME (First, Middle, Last): Raymond Grimes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Norma Pickett | |
| 19a. INFORMANT'S NAME (Type/Print): Robert Mullinix | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Sykesville, MD 21784 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Cemetery | 20c. LOCATION — City or Town, State: Sykesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight | | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX) SYKESVILLE, MD 21784 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE MYOCARDIAL INFARCTION WITH | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Complete HEART Block | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD. | 29c. LICENSE NUMBER: D19502 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-18-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ORLANDO B. CONAHAN, MD. BCGH-RANDALLSTOWN MD. 21133 | | |
| 31. DATE FILED (Month, Day, Year): MAY 19 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

5+l

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13253

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eugene Francis McCarthy Sr. | | | 2. DATE OF DEATH: MONTH May DAY 25 YEAR 1989 | 3. TIME OF DEATH: Unknown M |
| 4. SOCIAL SECURITY NUMBER: 214-20-2653 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 62 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9/10/26 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 3824 Byfield Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lochearn | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Lochearn | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3824 Byfield Road | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired: Self-Employed | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Chadwick McCarthy | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Estelle Miller | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Eugene McCarthy Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9421 Tiller Drive Ellicott City, MD 21043 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Mem. Park | 20c. LOCATION — City or Town, State: Sykesville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John K. Aymold | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 21133 8728 Liberty Road Randallstown, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. alcoholism — DUE TO (OR AS A CONSEQUENCE OF): — 32 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. — DUE TO (OR AS A CONSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley Z. Fisher Deputy Medical Examiner | 29c. LICENSE NUMBER: D01085 | 29d. DATE SIGNED (Month, Day, Year): ▶ May 26, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stanley Z. Fisher Randallstown MD 11 E. Chase St 21202 | | |
| 31. DATE FILED (Month, Day, Year): MAY 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Deputy Registrar | |

DHMH-16 Rev 1/89

88 13523

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13254
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Richard W. Norris, SR. | | | | 2. DATE OF DEATH: MAY 5, 1989 | 3. TIME OF DEATH: 3:00 P M |
| 4. SOCIAL SECURITY NUMBER: 217-26-9263 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): FEB. 1, 1932 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): woods behind 14 Foxbrier Lane | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 25 HOBAN COURT | | 10f. ZIP CODE: 21236 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: KOREAN | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): COLLEGE GRAD | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ASSISTANT VICE PRESIDENT | 16b. KIND OF BUSINESS/INDUSTRY: BANKING | | | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES HOWARD NORRIS, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY L. HUGHES | | | |
| 19a. INFORMANT'S NAME (Type/Print): MYRA L. NORRIS (WIFE) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 HOBAN COURT, BALTIMORE, MARYLAND 21236 | | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SECURITY PROCESS | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Drowning | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene | | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5/5/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Found in stream |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): stream | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Baltimore, MD rear of 14 Foxbrier Lane |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D., Acting Deputy Chief 111 Penn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Julia Davidson-Rudasill |

DHMH-16 Rev 1/89

88 1352f

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13255 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Nathaniel L. Nelson, Jr (LAND) | | | | 2. DATE OF DEATH: MONTH 5-10-89 DAY YEAR | 3. TIME OF DEATH: 11:55AM M |
| 4. SOCIAL SECURITY NUMBER: 216-80-6618 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 28 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9 22- 60 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): 1200 Block Valley Brook Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1913 Eutaw Place | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? U S A |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Nathaneil L. Nelson, Sr | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Norma Land |
| 19a. INFORMANT'S NAME (Type/Print): Cathy Nelson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1913 Eutaw Place Apt B1 Baltimore, Md 21217 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Mem Park | 20c. LOCATION — City or Town, State: Randallstown, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wound to abdomen and shotgun wound to face | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 XX Other (Specify) street | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 XX Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5-10-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 XX NO | 28d. DESCRIBE HOW INJURY OCCURED: subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): side of road | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1200 block Valley Brook Ct. Baltimore County, MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A. Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201 vc

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13256
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Hart Nicholson — Nicholson, Robert H
2. DATE OF DEATH (Month, Day, Year): 5-5-89 (5 / 5 / 89)
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 329-03-9561
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02/07/12
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): St Joseph Hospital / St. Joseph Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Towson / Towson
9c. COUNTY OF DEATH: Baltimore / Baltimore

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Phoenix
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3913 Longmoor Circle
10f. ZIP CODE: 21131
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Reg't Dietician
16b. KIND OF BUSINESS/INDUSTRY: City School Food Ser.
17. FATHER'S NAME (First, Middle, Last): Thomas Nicholson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Marie Hart
19a. INFORMANT'S NAME (Type/Print): R. Kent Nicholson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 Hollen Road, Baltimore, MD 21212
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc.
20c. LOCATION — City or Town, State: Catonsville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barry E. Mar
22. NAME AND ADDRESS OF FACILITY: Cremation Society of MD, Baltimore, Maryland 21228

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Aortic Stenosis — 5 years
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. Bleeding q/ts Aortic Valve Replacement — 2 hrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year):
26b. TIME OF INJURY:
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED:
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 5-6-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT K. BRAWLEY ST. JOSEPH HOSPITAL
31. DATE FILED (Month, Day, Year): MAY 8 _ 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13257 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lillian Katherine O'Rourke | | 2. DATE OF DEATH (Month, Day, Year): April 6, 1989 | 3. TIME OF DEATH: 7 a.m. M |
| 4. SOCIAL SECURITY NUMBER: 218-07-5850 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 4, 1913 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 200 Delight Road | 9b. CITY, TOWN OR LOCATION OF DECEDENT: Reisterstown | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: --- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5822 Clarks Hill Road | 10f. ZIP CODE: 21210 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home Making | |
| 17. FATHER'S NAME (First, Middle, Last): Frederick Ruff | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Rollins | | |
| 19a. INFORMANT'S NAME (Type/Print): Glenda Plummer | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Delight Rd., Reisterstown, Md. 21136 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Memorial Park | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. J. Eckhardt | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cancer of Lung DUE TO (OR AS A CONSEQUENCE OF): | 1y |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D18095 | 29d. DATE SIGNED (Month, Day, Year): ▶ 4-6-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 222 W Cold Spring Lane Balto Md 21210 | | |
| 31. DATE FILED (Month, Day, Year): APR 7 '89 | 32. REGISTRAR'S SIGNATURE: Lilia Davidson-Randall | |

DHMH-16 Rev 1/89

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13258
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James L OTES | | | 2. DATE OF DEATH (Month, Day, Year): May 22 1989 | 3. TIME OF DEATH: 6:45p. M |
| 4. SOCIAL SECURITY NUMBER: 212-01-4640 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): March 30, 1918 | 8. BIRTHPLACE (State or Foreign Country): W.VA. |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 102 Riverside Road | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Millrite | 16b. KIND OF BUSINESS/INDUSTRY: Beth Steel |
| 17. FATHER'S NAME (First, Middle, Last): Loranca Otes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): == | |
| 19a. INFORMANT'S NAME (Type/Print): Doris Otes | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 Riverside Road BAlto. Md. 21221 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Balto. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve.2122 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Entsr ths diseases, or complications that caused the death. Do not entar tha mode of dying, such ss cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximata Intarval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in daath) LAST
b. Cardiogenic Shock
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.: Metastatic Prostate Cancer

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 25a. DATE OF INJURY (Month, Day, Year) / 25b. TIME OF INJURY M / 25c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 25d. DESCRIBE HOW INJURY OCCURED | |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Alfred Covington MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 5/22/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alfred Covington, M.D. 9000 Franklin Square Drive, 21237 | | |
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

88 13528

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13259
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| James B. Pickett | | | May 12, 1989 | 2:10 aM |
| **4. SOCIAL SECURITY NUMBER** | **5. SEX** | **6. AGE (In yrs. last birthday)** | **7. DATE OF BIRTH (Month, Day, Year)** | **8. BIRTHPLACE (State or Foreign Country)** |
| 219-20-7837 | 1 [X] M 2 [ ] F | 62 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 2-10-1927 | Virginia |
| **9a. FACILITY NAME (If not institution, give street and number)** | **9b. CITY, TOWN OR LOCATION OF DEATH** | | **9c. COUNTY OF DEATH** | |
| Franklin Square Hospital | Batimore, Md. | | Baltimore County | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Baltimore | Baltimore | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 6920 Ebenezer Rd. | 21220 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 5th Grade | --- | Machinist | Furniture Co. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John B. Pickett | Birdie Lee Farrington |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. William Harvey | 6920 Ebenezer Rd. Balto., Md. 21220 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Glen Haven Cem. | Glen Burnie, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Hartley Miller | Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| **IMMEDIATE CAUSE (Final disease or condition resulting in death)** → | a. Congestive heart failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| **Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST** | b. Chronic renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

Diabetes Mellitus

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: [X] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Madhu Chaudhry | | ▶ 5/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MADHU CHAUDHRY, FRANKLIN SQUARE

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | Julia Davidson-Randazzo |

DHMH-18 Rev 1/89

88 13528

89 13260

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 4 is the transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY BRACKEN PETTIJOHN | | 2. DATE OF DEATH (Month, Day, Year): April 27, 1989 | 3. TIME OF DEATH: 7:50 P M |
| 4. SOCIAL SECURITY NUMBER: 358-26-1461 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 9, 1906 |
| 8. BIRTHPLACE (State or Foreign Country): Ohio | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Natchcliff Retirement Community | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Arm | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Glen Arm | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 11630 Glen Arm Rd. L61 | 10f. ZIP CODE: 21057 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 16; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Harry E. Bracken | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola Stoll | | |
| 19a. INFORMANT'S NAME (Type/Print): Francis J. Pettijohn | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11630 Glen Arm Rd. L61, Glen Arm, MD 21057 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gdns. | 20c. LOCATION — City or Town, State: Timonium, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. George Altenburg | 22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd. Baltimore, MD 21214 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-Pulmonary Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Cerebrovascular Accident | Month. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MP | 29c. LICENSE NUMBER: 027975 | 29d. DATE SIGNED (Month, Day, Year): 4/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID McClure M.D. 1131 Bel Air Road Bel Air, Md 21014 | | |
| 31. DATE FILED (Month, Day, Year): MAY 1 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13261

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lillian PARKER | | | | 2. DATE OF DEATH (Month, Day, Year): 5 - 6 - 89 | 3. TIME OF DEATH: 210 P M |
| 4. SOCIAL SECURITY NUMBER: 146-12-9637 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-14-01 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Sykesville | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7010 Jennifer Way | | 10f. ZIP CODE: 21784 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Keene | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Ward | | |
| 19a. INFORMANT'S NAME (Type/Print): Ella Mae Evans | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7010 Jennifer Way, Sykesville, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restland Memorial Park | | 20c. LOCATION — City or Town, State: E. Hanover, N.J. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. George Altenburg | | 22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. End stage Chronic Obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cor pulmonale
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Sie Kien Ong M.D. House physician | D36456 | ▶ 5/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sie Kien Ong M.D. Baltimore County General Hospital, Randallstown MD 21133

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 5/6/89 MAY 10 1989 | Julia Davidson-Randall |

DHMH-t6 Rev 1/89

Item#7 Film#g651 05/18/89 daa

per F.H. 7

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13262
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HENRY C POWELL | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 14 / 89 | 3. TIME OF DEATH: 9:27P M |
| 4. SOCIAL SECURITY NUMBER: 215-03-4152 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 ~~83~~ YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. 11/03/1906 ~~11/02/905~~ | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: RUXTON | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 7001 N. CHARLES STREET | | 10f. ZIP CODE: 21204 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PIPE COVERER | | 16b. KIND OF BUSINESS/INDUSTRY: WALLIS ASBESTOS |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM A. POWELL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE MELTON | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. JANE GILPIN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9525 HOLIDAY MANOR, BALTIMORE, MARYLAND 21236 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz, Jr. | | 22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION. | HOURS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROSIS.
ASBESTOSIS.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D-12849. | ▶ 5-16-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABDOLHAMID GHILADI M.D. 7600 OSLER Dr. Towson Md 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | [signature] |

DHMH-16 Rev 1/89

88 13585

89 13263

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5, should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marc JEFFREY Perlow | | | | 2. DATE OF DEATH (Month, Day, Year): 5-4-89 | 3. TIME OF DEATH: 2:05PM M |
| 4. SOCIAL SECURITY NUMBER: 220-54-8486 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 38 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): AUG. 12, 1950 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 7027 Liberty Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Woodlawn | | 9c. COUNTY OF DEATH: Baltimore County | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 2601 Old Court Rd. | | 10f. ZIP CODE: 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES: X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MERCHANT | | 16b. KIND OF BUSINESS/INDUSTRY: RETAIL | |
| 17. FATHER'S NAME (First, Middle, Last): JEROME PERLOW | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GERTRUDE BLITZER | | | |
| 19a. INFORMANT'S NAME (Type/Print): JEROME PERLOW | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3515 OLD COURT RD. BALTO., MD 21208 | | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PROGRESSIVE BENEFIT & RELIEF ASSOC. | | 20c. LOCATION — City or Town, State: RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellensue Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wound to head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): jewelry store | | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5-4-89 | 28b. TIME OF INJURY: 2:00PM | 28c. INJURY AT WORK? [X] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED: subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): store | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 7027 Liberty Road, Baltimore Co. Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin M.D. | OCME | ▶ 5-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 9 1989 | [illegible] |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13264

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Miriam PARKS | | | 2. DATE OF DEATH (Month, Day, Year): 5 21 89 | 3. TIME OF DEATH: 040 A M |
| 4. SOCIAL SECURITY NUMBER: 216-03-3028A | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11 25 01 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1328 Willow Spring Road | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEHDENT OF HISPANIC ORIGIH? (Specify Yes or Ho--- If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ HO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Saleslady | 16b. KIHD OF BUSIHESS/IHDUSTRY: Brager-Eisenberg | | |
| 17. FATHER'S HAME (First, Middle, Last): George Wesley Towers | | 18. MOTHER'S HAME (First, Middle, Maiden Surname): Mary Garner | | |
| 19a. INFORMANT'S HAME (Type/Print): Mrs. Ida Lee Daniels | | 19b. MAILIHG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1328 Willow Spring Rd. Catonsville, MD 21228 | | |
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | | 20c. LOCATIOH — City or Town, State: Parkville, Maryland |
| 21. SIGHATURE OF FUNERAL SERVICE LICEHSEE: ▶ John K Aymold Jr | | 22. NAME AHD ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Rd. Randallstown, MD 21133 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUEHCE OF):

d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Atrial fibrillation

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FIHDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MAHHER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYIHG PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGHATURE AND TITLE OF CERTIFIER: Barbara Socha, M.D. | 29c. LICEHSE HUMBER: D35609 | 29d. DATE SIGHED (Month, Day, Year): ▶ 5/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Barbara Socha 5401 Old Court Rd., Randallstown, MD 21133 | | |
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGHATURE: Julia Dixon-Parker | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13265
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Merryman M. Price | | | 2. DATE OF DEATH (Month, Day, Year): 4 / 10 / 89 | 3. TIME OF DEATH: 1:00 a M |
| 4. SOCIAL SECURITY NUMBER: 213-05-4898A | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 7, 1916 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 209 Parkholme Cir. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Reisterstown | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 209 Parkholme Cir. | | 10f. ZIP CODE: 21136 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electroplater | 16b. KIND OF BUSINESS/INDUSTRY: Martin's | | |
| 17. FATHER'S NAME (First, Middle, Last): William Sterling Price, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Frantz | | |
| 19a. INFORMANT'S NAME (Type/Print): D. Elaine Whitehead | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 716 Joppa Farm Rd., Joppa, MD 21085 | | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. George Attenburg | 22. NAME AND ADDRESS OF FACILITY: ROBERT C.A LTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN Death

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hypertensive Heart Disease

DUE TO (OR AS A CONSEQUENCE OF):

c. DIABETES

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 4-10-89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED: Found Dead in Bed |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Craig M Haber MD | 29c. LICENSE NUMBER: D24866 | 29d. DATE SIGNED (Month, Day, Year): 4-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Craig Haber MD 5 Chartley Park Rd Reisterstown 21136

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 13265

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13266
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TRAVEL (NMI) POWELL — Travels Powell
2. DATE OF DEATH: MONTH 05 DAY 15 YEAR 89
3. TIME OF DEATH: 742 P M
4. SOCIAL SECURITY NUMBER: 215 24 7058
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-26-19
8. BIRTHPLACE (State or Foreign Country): N. Carolina
9a. FACILITY NAME (If not institution, give street and number): Univ. of Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 601 N. FREMONT AVE
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [#] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Taft Holiday
18. MOTHER'S NAME (First, Middle, Maiden Surname): Georgeanna Holiday
19a. INFORMANT'S NAME (Type/Print): Donald Knight
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1058 Drgylee Ave. Baltimore. Md. 21201 Apt. 7 G
20a. METHOD OF DISPOSITION: 1 [#] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans
20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Cecil A Estep
22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home P.A. 1300 Eutaw Place

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End Stage renal failure — 2 wks

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

S/P acute inferior myocardial infarction
Lower GI bleeding
(R) lower lobe pneumonia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jean K. Warner MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 5/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jean K. Warner MD

31. DATE FILED (Month, Day, Year): MAY 19 1989
32. REGISTRAR'S SIGNATURE: Lia Pender-Rankin

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13267
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RUTH POLANSKY | | | 2. DATE OF DEATH (Month, Day, Year): MAY 15, 1989 | 3. TIME OF DEATH: 7 10 A.M |
| 4. SOCIAL SECURITY NUMBER: 218-18-4369 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JUNE 1, 1923 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 7201 CAMPFIELD RD. 21207 | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7201 CAMPFIELD RD. | | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME |
| 17. FATHER'S NAME (First, Middle, Last): MAX GOLDMAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): REBECCA HIRSHOWITZ | | |
| 19a. INFORMANT'S NAME (Type/Print): JEROME POLANSKY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7201 CAMPFIELD RD. BALTO., MD 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH EL MEMORIAL PARK | | 20c. LOCATION — City or Town, State: RANDALLSTOWN, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jack H. Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. LUNG CANCER | 9 MOS. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| G I. Ch MD. | 027730 | ▶ 5/15/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GARY COHEN, MD. 711 W. 40th ST. BALTO MD 21211

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 19 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

Case: 89 1327

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13268
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donnette Judith Paciocco-Pizlo | | | | 2. DATE OF DEATH (Month, Day, Year): 5-15-89 | 3. TIME OF DEATH: 1:30PM M |
| 4. SOCIAL SECURITY NUMBER: 216-88-4368 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 27 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan 17,1962 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 711 49th Street | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore County | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 711 49th Street | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Harbor Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Paciocco | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy A. Smith | |
| 19a. INFORMANT'S NAME (Type/Print): Melvin Pizlo Sr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711 49th Street Balto. Md. 21224 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process Inc. | 20c. LOCATION — City or Town, State: BAlto. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hanging

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5-15-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: subject hanged self | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 711 49th Street, Balto.Co. |

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 5-16-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 | | VC |
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

88 13508

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13269 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): George PHELPS | | | 2. DATE OF DEATH (Month, Day, Year): May 16, 1989 | 3. TIME OF DEATH: 3:55 a M |
| 4. SOCIAL SECURITY NUMBER: 218-12-4395 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Oct. 9, 1922 | 8. BIRTHPLACE (State or Foreign Country): MAryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 201 A Middleway | | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW11 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): George M. Phelps | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Konop | |
| 19a. INFORMANT'S NAME (Type/Print): Linda Rodgers | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1323 Mohr's Lane BAlto. Md. 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest | 20c. LOCATION — City or Town, State: Baltimore Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAVe. 2122 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac dysrythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Congestive heart failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Seidenberg, M.D. 9000 Franklin Square Drive 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13270 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHESTER GEORGE PIASKOWSKI, JR. | | | | 2. DATE OF DEATH: MONTH 5 DAY 15 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 212-44-4080 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 43 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-23-1945 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 2929 LIBERTY PARKWAY | | | 9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2929 LIBERTY PARKWAY | | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSTRUCTION WORKER | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| 17. FATHER'S NAME (First, Middle, Last): CHESTER GEORGE PIASKOWSKI, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE JOHANNA MOHR | | | |
| 19a. INFORMANT'S NAME (Type/Print): LORA LEE PIASKOWSKI | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7829 S.T FABIAN LANE BALTIMORE, MARYLAND 21222 | | | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY MAY 20, 1989 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Collins | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Self-inflicted hanging and suffocation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 5-15-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2929 LIBERTY PARKWAY BALTO., MD. 21222 | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. Crossan O'Donovan | 29c. LICENSE NUMBER: D07632 | 29d. DATE SIGNED (Month, Day, Year): 5-17-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. CROSSAN O'DONOVAN 2112 DUNDALK AVE. BALTO MD. 21222

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89-13271 REG. NO. ~~89-13271~~

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SAMUEL F. PYLE (SAMUEL F. PYLE) | | | | 2. DATE OF DEATH: MONTH MAY 8, DAY 9, YEAR 1989 | 3. TIME OF DEATH: 12:25 A M |
| 4. SOCIAL SECURITY NUMBER: 215-12-5817 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 3, 1918 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL (ST JOSEPH Hospital) | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE (BALTIMORE) | | 9c. COUNTY OF DEATH: BALTIMORE (COUNTY) |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2-D SOMMERVILLE COURT | | | 10f. ZIP CODE: 21234 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AUTO WORKER | | 16b. KIND OF BUSINESS/INDUSTRY: GENERAL MOTORS |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL J. PYLE | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): STREETT | |
| 19a. INFORMANT'S NAME (Type/Print): GLADYS JEAN PYLE | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2-D SOMMERVILLE COURT, BALTIMORE, MARYLAND 21234 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dennis A Capitano | | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Upper G I Bleed, complicated by | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Renal Failure Heart failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure; Congestive Heart Failure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify); 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John A Cavanaugh MD. | D25910 | ▶ 5/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 12 1989 | Julia Davidson-Landeau |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13272

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) PAUL L. PLACK, SR / PAUL L PLACK SR. | | | 2. DATE OF DEATH (Month / Day / Year) 5 / 5 / 89 | 3. TIME OF DEATH 0928 M |
| 4. SOCIAL SECURITY NUMBER 212-09-3005 | 5. SEX 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday) 72 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year) July 28, 1916 | 8. BIRTHPLACE (State or Foreign Country) Maryland |
| 9a. FACILITY NAME (If not institution, give street and number) St JOSEPH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH TOWSON MARYLAND | | 9c. COUNTY OF DEATH BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Md | 10b. COUNTY BALtimore | 10c. CITY, TOWN OR LOCATION Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER 600 SQUIRES Rd. | | 10f. ZIP CODE 21204 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White CAUCASIAN |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Attorney | 16b. KIND OF BUSINESS/INDUSTRY Safeco Co. | |
| 17. FATHER'S NAME (First, Middle, Last) Harry David Plack | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elinor Lazzell | |
| 19a. INFORMANT'S NAME (Type/Print) Paul L. Plack, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 Edgewood Rd., Balto., Md. 21234 | |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Maus. 5/8/89 | 20c. LOCATION — City or Town, State Timonium, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Wallace S. Brooks Jr. | | 22. NAME AND ADDRESS OF FACILITY 1050 York Rd., Towson, Md. 21204 RUCK Towson Funeral Home, Inc. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | MYOCARDIAL INFARCTION | 2 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Francis Khoo MD, Staff physician | 29c. LICENSE NUMBER D 30263 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-5-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS T. KHOO ST. JOSEPH HOSPITAL 7620, YORK RD, TOWSON, MD | | |
| 31. DATE FILED (Month, Day, Year) MAY 8 1989 | 32. REGISTRAR'S SIGNATURE Julie Davidson-Randall | 21204 |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13273

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDNA PAYNE | | | | | 2. DATE OF DEATH (Month, Day, Year): 5 6 89 | 3. TIME OF DEATH: 6 A M | |
| 4. SOCIAL SECURITY NUMBER: 212-32-2971 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 100 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): NOV. 19, 1888 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number): FREDERICK VILLA NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | | | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 439 PARADISE AVE. | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): ERNEST PEARSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE SOMMES | |
| 19a. INFORMANT'S NAME (Type/Print): ALMA JENKINS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 439 PARADISE AVE. CATONSVILLE, MD. 21228 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: 1630 EDMONDSON AVE. CATONSVILLE, MD. 21228 LEROY M. & RUSSELL C. WITZKE FUNERAL HOME | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure
Aortic stenosis, Mitral regurgitation
Degenerative arthritis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D28236 | 29d. DATE SIGNED (Month, Day, Year): 5/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dorian St Martin 5911 Old Frederick Rd Balto 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 8 - 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13274

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis Joseph Postlethwait
2. DATE OF DEATH (Month, Day, Year): May 9 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 317 10 9346
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01 16 16
8. BIRTHPLACE (State or Foreign Country): Penna. U.S.A.
9a. FACILITY NAME (If not institution, give street and number): 335 Leeann Road
9b. CITY, TOWN OR LOCATION OF DEATH: Essex 21221
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore County
10c. CITY, TOWN OR LOCATION: Essex 21221
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 335 Leeann Road
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: World War 2
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 th Grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic
16b. KIND OF BUSINESS/INDUSTRY: Automotive
17. FATHER'S NAME (First, Middle, Last): James E. Postlethwait
18. MOTHER'S NAME (First, Middle, Maiden Surname): Miranda Turley
19a. INFORMANT'S NAME (Type/Print): Irene M. Postlethwait (wife)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 335 Leeann Road Baltimore Maryland 21221
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial
20c. LOCATION — City or Town, State: Baltimore County Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶
22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave Balto. Maryland 21221

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARCINOMA OF LUNG (Adenocarcinoma)
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. End Stage Chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Atherosclerosis.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D18326
29d. DATE SIGNED (Month, Day, Year): ▶ 5/9/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 404-406 Eastern Blvd 21221 Dr. N. Gauhar
31. DATE FILED (Month, Day, Year): MAY 9 1989 — REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13275

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be obtained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be destroyed for use as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NELSON H. PIERCE | | | | 2. DATE OF DEATH (Month, Day, Year): May 20, 1989 | 3. TIME OF DEATH: 8:30 A. M |
| 4. SOCIAL SECURITY NUMBER: 212-26-0279 | 5. SEX: 1 [X] M 2 [ ] F | 8. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-28-1928 | 6. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 404 Bloomsbury Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 404 Bloomsbury Ave. | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korea | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Inspector | | 16b. KIND OF BUSINESS/INDUSTRY: Western Electric | |
| 17. FATHER'S NAME (First, Middle, Last): Walter Pierce | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Burr | | | |
| 19a. INFORMANT'S NAME (Type/Print): Jane L. Pierce | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 Bloomsbury Ave. Catonsville MD. 21228 | | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westview Crematory | | 20c. LOCATION — City or Town, State: Catonsville MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Leroy M. & Russell C. WitzkeFuneral Homes 1630 Edmondson Ave. Catonsville MD. 21228 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Could not be determined 6 [ ] Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Patrick W. White | D23365 | ▶ 5/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PATRICK W. WHITE M.D. 299 FREDERICK ROAD, BALTIMORE, MARYLAND 21228

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | [signature] |

OHMH-16 Rev 1/89

89 13276

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Pages 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHRISTOS J. PANTELIS | | | 2. DATE OF DEATH (Month, Day, Year): MAY 22, 1989 | 3. TIME OF DEATH: 1:10 A. M |
| 4. SOCIAL SECURITY NUMBER: 114-01-4354 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 10, 1901 | 8. BIRTHPLACE (State or Foreign Country): TURKEY |
| 9a. FACILITY NAME (If not institution, give street and number): FREDERICK VILLA NURSING CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 5552 CHANNING ROAD | | 10f. ZIP CODE: 21229 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SHORT ORDER COOK | 16b. KIND OF BUSINESS/INDUSTRY: RESTAURANT | | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN PANTELIS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIA PAPADAKIS | | |
| 19a. INFORMANT'S NAME (Type/Print): KATHY FANTOPOULOS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7115 CHAMBERLAIN ROAD, BALTIMORE, MARYLAND 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEK ORTHODOX CEMETERY | 20c. LOCATION — City or Town, State: WOODLAWN, MARYLAND | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell Witzke | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrest ; Dehydration | — |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Fever of unknown Origin | 1 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Arteriosclerosis

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Kennard Yaffee M.D. | D 11977 | ▶ 5/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KENNARD YAFFEE M.D., 5501 FOREST PARK AVENUE, BALTIMORE, MD. 21207

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 13277

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDEHT'S HAME (First, Middle, Last): Ruth Pumphrey | | | 2. DATE OF DEATH: MONTH 5 DAY 29 YEAR 89 | 3. TIME OF DEATH: 12:10 A. M |
| 4. SOCIAL SECURITY HUMBER: 218-01-0430 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Sept. 23, 1900 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Riverview Nursing Centre | | 9b. CITY, TOWN OR LOCATION OF DEATH: Essex | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUHTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | | 10d. IHSIDE CITY LIMITS? 1 ☐ YES 2 ☒ HO |
| 10e. BTREET AND NUMBER: 17 Cromwell Ave. | | 10f. ZIP CODE: 21061 | | 10g. CITIZEN OF WHAT COUHTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ HO IF YES, GIVE WAR OR DATES | 13. WAS DECEHDENT OF HISPANIC ORIGIH? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ HO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Commisary Clerk | | 16b. KIND OF BUSINESS/INDUSTRY: Ft. Meade | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Wesley Upton | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Idella Ward | | |
| 19a. INFORMANT'S NAME (Type/Print): Ramona Fox | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Cromwell Ave., Glen Burnie, MD 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Brooklyn Pk., A.A., MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. HAME AHD ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie MD 21061 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Coronary Vascular Disease

OUE TO (OR AS A CONSEQUEHCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A COHSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUEHCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Colon Carcinoma, old automobile accident - cardiac arrhythmia

24a. WAS AH AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ HO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ HO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ HO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYIHG PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGHED (Month, Day, Year) |
|---|---|---|
| Michael Schwartzod MD | D 19667 | ▶ May 29, 89 |

30. HAME AHD ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Schwartzod 606 Hammonds Lane Balto Md 21225

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGHATURE |
|---|---|
| JUN 01 1989 | Gisha Davidson-Tyndall |

DHMH-16 Rev 1/89

89 13278

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ernest W. Page Sr. | | | 2. DATE OF DEATH (Month, Day, Year): 5 26 89 | 3. TIME OF DEATH: 3:25 A M |
| 4. SOCIAL SECURITY NUMBER: 218-01-0702 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7 17 17 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County Gen. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Owings Mills | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 9806 Lyons Mill Rd. | | 10f. ZIP CODE: 21117 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4 or 6+): – | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Air Conditioning Technician | | 16b. KIND OF BUSINESS/INDUSTRY: Wakefield Apartments |
| 17. FATHER'S NAME (First, Middle, Last): George N. Page | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Whittington | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Carolyn Page | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9806 Lyons Mill Rd. Owings Mills, MD 21117 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gardens | | 20c. LOCATION — City or Town, State: Cockeysville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John K Arnold | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Rd. Randallstown, MD 21133 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA of lung with metastases

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Barbara Socha, M.D. | D35609 | ▶ 5/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA Socha 5401 Old Court Rd., Randallstown, MD 21133

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13279 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALBERT ARTHUR ROBERTS, SR. | | | 2. DATE OF DEATH (Month, Day, Year): MAY 16, 1989 | 3. TIME OF DEATH: 5:55 A M |
| 4. SOCIAL SECURITY NUMBER: 012-10-6318 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 29, 1903 | 8. BIRTHPLACE (State or Foreign Country): Maine |
| 9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 427 Kenneth Square | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): 4 Years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Civil Engineer | 16b. KIND OF BUSINESS/INDUSTRY: Lever Bros. | |
| 17. FATHER'S NAME (First, Middle, Last): Frederick Arthur Roberts | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Small | |
| 19a. INFORMANT'S NAME (Type/Print): Albert A. (ROB) Roberts, Jr. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 427 Kenneth Square Baltimore, Md. 21212 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens | 20c. LOCATION — City or Town, State: Timonium, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Bunnell Jr. | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory arrest | minutes |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. OUE TO (OR AS A CONSEQUENCE OF): | |
| | c. OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARKINSON'S DISEASE
MULTI-INFARCT DEMENTIA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Theodore Kramer MD | 29c. LICENSE NUMBER: D31564 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-17-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7801 York Rd Suite 100 Towson, MD 21204 | | |
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Sue Davidson-Kendall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13280
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bernard F. Rogers | | | 2. DATE OF DEATH (Month, Day, Year): 5 14 89 | 3. TIME OF DEATH: 7:28 a M |
| 4. SOCIAL SECURITY NUMBER: 213-07-2978 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/30/11 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1111 S. East Avenue | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): electric welder | 16b. KIND OF BUSINESS/INDUSTRY: | | |
| 17. FATHER'S NAME (First, Middle, Last): Frank Rogers | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Williams | | |
| 19a. INFORMANT'S NAME (Type/Print): Dolores M. Rogers | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 S. East Ave. Balto. MD 21224 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus | 20c. LOCATION — City or Town, State: Baltimore, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Moran Funeral Home 3000 E. Baltimore St. Balto. MD 21224 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Bilateral hip fracture | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 4-7-89 | 10:30A M | 1 [ ] YES 2 [X] NO | subject fell |
| **28e. PLACE OF INJURY — At home, farm, street, factory, building, etc. (Specify)** | | **28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)** | |
| home | | 1111 S. East Avenue | |

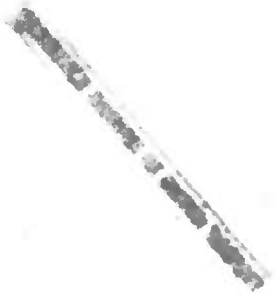
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Wilmot Ball, MD | D220 | 5/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print):

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | [signature] |

DHMH-18 Rev 1/89



08 13580

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13281

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert G. Rauch (Robert G Rauch) | | | 2. DATE OF DEATH: MONTH 5 DAY 23 YEAR 89 | 3. TIME OF DEATH: 1140 A M |
| 4. SOCIAL SECURITY NUMBER: 212-78-9075 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 28 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8 24 60 | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: ------- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 146 W. Lanvale Street | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 2 yrs. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | 16b. KIND OF BUSINESS/INDUSTRY: Car Rental, Co. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): "Unknown to Records" | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jean Gage |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Jean G. Littrell | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 146 W. Lanvale Street, Balto., MD 21217 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process, Inc. | 20c. LOCATION — City or Town, State: Catonsville, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George E. MacNabb | 22. NAME AND ADDRESS OF FACILITY: Cremation Society of Maryland | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. AIDS - acquired immune deficiency syndrome | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carla S. Alexander, MD | 29c. LICENSE NUMBER: D27087 | 29d. DATE SIGNED (Month, Day, Year): 5-23-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] |

DHMH-16 Rev 1/89

Items 23a thu28f PerM E FilMC653 7/28/89cg

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13282

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frederick Charles Roth Jr. | | | 2. DATE OF DEATH (Month, Day, Year): 5-4-89 | 3. TIME OF DEATH: 4:30PM M |
| 4. SOCIAL SECURITY NUMBER: 218 58 9192 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 3, 1952 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 2233 Old Eastern Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Middle River | | 9c. COUNTY OF DEATH: Baltimore County |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2233 Old Eastern Ave. | | 10f. ZIP CODE: 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+): — | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House Keeping | | 16b. KIND OF BUSINESS/INDUSTRY: Nursing Center |
| 17. FATHER'S NAME (First, Middle, Last): Fredrick C. Roth, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Watson | | |
| 19a. INFORMANT'S NAME (Type/Print): Jennie Roth | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4849 Philadelphia Road Aberdeen, Md. 21001 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrhythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D.

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 5-5-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year): MAY 9 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Kemp

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 13283

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13283

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Roy C. Ross | | | | 2. DATE OF DEATH: Month 4, Day 9, Year 89 | 3. TIME OF DEATH: 11:30 AM |
| 4. SOCIAL SECURITY NUMBER: 168-12-9905 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5/22/22 | 8. BIRTHPLACE (State or Foreign Country): PA |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson / Balto | | 9c. COUNTY OF DEATH: Md. Balto. County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Cockeysville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 10306 A Malcolm Circle | | 10f. ZIP CODE: 21030 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Repairman | 16b. KIND OF BUSINESS/INDUSTRY: Ingersoll Rand |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Roy Camp Ross | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Breece |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Beryl V. Ross | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10306 A Malcolm Circle, Cockeysville, Md. 21030 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens | 20c. LOCATION — City or Town, State: Timonium, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bryan W. Clary | 22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd., Timonium, Md. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Emphysema | 10 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Chronic Obstructive Pulmonary Disease | 12 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year): N/A | 26b. TIME OF INJURY: N/A M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED: N/A |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Duane Smoot MD | 29c. LICENSE NUMBER: D 31831 | 29d. DATE SIGNED (Month, Day, Year): 4/9/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Duane Smoot MD 7620 York Road Towson, Md. 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): APR 13 1989 | 32. REGISTRAR'S SIGNATURE: Jane Dugan-Randell |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13284

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Hilda Rae Fowble Regler | | | | | 2. DATE OF DEATH: MONTH May DAY 22 YEAR 1989 | | 3. TIME OF DEATH: 3:00 P M |
| 4. SOCIAL SECURITY NUMBER: 215-05-6822 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 1 1918 | | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Manor Care Nursing Home-Towson | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | | 9c. COUNTY OF DEATH: Baltimore County | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | | 10c. CITY, TOWN OR LOCATION: Cockeysville | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 12304 Happy Hollow Rd. | | | 10f. ZIP CODE: 21030 | | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking | |
| 17. FATHER'S NAME (First, Middle, Last): William Arthur Fowble | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Alverta Cole | | | | |
| 19a. INFORMANT'S NAME (Type/Print): W. Ralph Regler | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12304 Happy Hollow Rd., Cockeysville, Md. 21030 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park | | | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Martin D. Lawson | | | 22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md.21093 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha death. Do not anter tha mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. List only ona cause on esch line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pick's Disease (Pick's Disease) DUE TO (OR AS A CONSEQUENCE OF): | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Diabetes (Diabetes) DUE TO (OR AS A CONSEQUENCE OF): | year |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Philip Konito | D24321 | ▶ 5 24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Philip Konito 100 Owings Ct Reisterstown Md 21136

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 26 1989 | Julia Davidson-Andrews |

DHMH-16 Rev 1/89

25

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13285
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PEARL RAYNOR | | | 2. DATE OF DEATH (Month, Day, Year): MAY 10, 1989 | 3. TIME OF DEATH: 5:15 AM M |
| 4. SOCIAL SECURITY NUMBER: 220-44-4811 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): NOV. 14, 1901 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): JEWISH CONVALESCENT CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6932 REISTERSTOWN RD. | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH ROSENSTEIN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE MASHBAUM | |
| 19a. INFORMANT'S NAME (Type/Print): BERNARD RAYNOR | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6606 PARK HTS. AVE, APT. 208 BALTO., MD 21215 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HEBREW YOUNG MENS CEMETERY- | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellensue Levinson | | 22. NAME AND ADDRESS OF FACILITY: Sol Levinson & Bros., Inc. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | MYOCARDIAL INFARCTION (probable) DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. | ARTHEROSCLERONIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF): | |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jon Sunshine M.D. | 29c. LICENSE NUMBER: D15140 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JON SUNSHINE M.D. 6210 PARK HTS. Ave, BALT, MD 21215 | | |
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Gordon-Randall | |

3

DHMH-16 Rev 1/89

08 13502

Item4 5-23-89 Film G651
W.H. Per F/H

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13286 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Benson Randolph
2. DATE OF DEATH: MONTH 5 DAY 12 YEAR 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NO.: 218-05-0289 ~~220-09-2981~~
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-19-19
8. BIRTHPLACE (State or Foreign Country): Maryland

RESIDENCE OF DECEDENT

9a. FACILITY NAME (If not institution, give street and number): 837 Quaker Bottom Road
9b. CITY, TOWN OR LOCATION OF DEATH: Sparks
9c. COUNTY OF DEATH: Baltimore

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Sparks
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 837 Quaker Bottom Road
10f. ZIP CODE: 21152
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW2
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ___ College (1-4 or 5+): ___
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steelworker
16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steele

17. FATHER'S NAME (First, Middle, Last): William Randolph
18. MOTHER'S NAME (First, Middle, Maiden Surname): Georgia Payne

19a. INFORMANT'S NAME (Type/Print): Ruth Randolph
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 837 Quaker Bottom Road Sparks, Maryland 21152

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ___
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem.
20c. LOCATION — City or Town, State: Owings Mills, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Harris
22. NAME AND ADDRESS OF FACILITY: Chatman-Harris Funeral Home 1701 McCulloh Street Balto. Md. 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of Lung
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D19164
29d. DATE SIGNED (Month, Day, Year): ▶ 5/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): MAY 15 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13287
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FLORENCE F. ROSE | | | 2. DATE OF DEATH: MONTH 05 DAY 2 YEAR 89 | 3. TIME OF DEATH: 10:05A M | |
| 4. SOCIAL SECURITY NUMBER: 564-48-5816 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05-04-07 | 8. BIRTHPLACE (State or Foreign Country): Balto. | |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Multi Medical | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: Balto. | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: CALIFORNIA | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: PALM SPRINGS | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 798 DRY FALLS RD. | | 10f. ZIP CODE: 92262 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES N/A | 13. WAS DECEHDENT OF HISPAHIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ HO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do HOT use retired.): HOUSEWIFE | | 16b. KIHD OF BUSINESS/INDUSTRY: AT HOME | |
| 17. FATHER'S NAME (First, Middle, Last): ISRAEL JACOB BROWN | | 18. MOTHER'S NAME (First, Middle, Malden Surname): FANNIE FISTEL | | | |
| 19a. IHFORMANT'S HAME (Type/Print): HAROLD I. GLASER | | 19b. MAILIHG ADDRESS (Street and Humber or Rural Route Humber, City or Town, State, Zip Code): 201 N. CHARLES ST., SUITE 1717 BALTO., MD 21201 | | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Hame of cemetery, crematory or other place): CHIZUK AMUNO (ARLINGTON) | | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGHATURE OF FUHERAL SERVICE LICEHSEE: Joel D Levin | | 22. HAME AHD ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on aech lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | sepsis DUE TO (OR AS A CONSEQUENCE OF): | 5 days |
| Sequentially list conditions, if sny, leading to immedieta cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. | senile dementia DUE TO (OR AS A CONSEQUENCE OF): | 3 years |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Othar significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERREO TO MEOICAL EXAMIHER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Humber or Rural Route Humber, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGHATURE AHD TITLE OF CERTIFIER | 29c. LICENSE HUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Carl S Friedman MD M.D | D20688 | 5/2/89 |

30. HAME AHD ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carl S. Friedman, M.D., 660 Kenilworth Dr, Towson, Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 4 1989 | Ruth Davidson-Randall |

DHMH-18 Rev 1/89

89 13287

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13288 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KATHERINE S. ROBERTS
2. DATE OF DEATH MONTH 5 DAY 1 YEAR 89
3. TIME OF DEATH 11 A M
4. SOCIAL SECURITY NUMBER: 216-50-0606
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-22-06
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 6 Over Ridge Court
9b. CITY, TOWN OR LOCATION OF DEATH: Balto.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 6 Over Ridge Court
10f. ZIP CODE: 21210
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John H. K. Shannahan
16. MOTHER'S NAME (First, Middle, Maiden Surname): Beulah Day
19a. INFORMANT'S NAME (Type/Print): Katherine R. Merrifield
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1115 39th Ave. East, Seattle, Wash. 98112
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John a Slade
22. NAME AND ADDRESS OF FACILITY: 4905 York Rd. H.W. Jenkins & Sons Co., Balto., Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Probable cerebral hemorrhage — few minutes

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): b. (previous recent dizziness)

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: W. Daniels Jr MD
29c. LICENSE NUMBER: D-02225
29d. DATE SIGNED (Month, Day, Year) ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WORTH B. DANIELS JR. M.D. 11 E. CHASE ST., BALTO., MD. 21202
31. DATE FILED (Month, Day, Year): MAY 4 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Mooney

DHMH-16 Rev 1/89

6 Over Ridge Court

6 OverRidge Court

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13289

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Veronica Elizabeth Roman

**2. DATE OF DEATH** Month: 5 Day: 11 Year: 89

**3. TIME OF DEATH**: 6:00 p M

**4. SOCIAL SECURITY NUMBER**: 101-14-7909

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 66 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 3 16 23

**8. BIRTHPLACE** (State or Foreign Country): New York

**9a. FACILITY NAME** (If not institution, give street and number): 9 Sugar Loaf Court - Apt. T

**9b. CITY, TOWN OR LOCATION OF DEATH**: Pikesville

**9c. COUNTY OF DEATH**: Baltimore Co.

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Baltimore County

**10c. CITY, TOWN OR LOCATION**: Pikesville

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 9 Sugar Loaf Ct. Apt. T

**10f. ZIP CODE**: 21209

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 years
College (1-4 or 5+): 2 years

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Secretary

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Michael Roman

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Anna Brecko

**19a. INFORMANT'S NAME** (Type/Print): Michael R. Dancik

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Fourth Street, Voorhees, New Jersey 08043

**20a. METHOD OF DISPOSITION**: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Greenmount Cemetery

**20c. LOCATION — City or Town, State**: Baltimore City

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: John E. Ross

**22. NAME AND ADDRESS OF FACILITY**: Mitchell-Wiedefeld Home
6500 York Rd. Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE** (Final disease or condition resulting in death) →
a. Strangulation, Multiple blunt injuries to head and [illegible]

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
b. chest and fracture-dislocation of cervical spine
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: multiple healing right rib and clavicular fractures

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☒ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☒ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☒ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year): est. 5/9/89

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☒ NO

**28d. DESCRIBE HOW INJURY OCCURED**: Subject was Strangled and beaten

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify): home

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State): 9 Sugar Loaf Court, Balt. Co. Md.

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Julia C. Goodin

**29c. LICENSE NUMBER**: OCME

**29d. DATE SIGNED** (Month, Day, Year): 5/12/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Julia C. Goodin, M. D. 111 Penn Street Baltimore, Maryland 21201

**31. DATE FILED** (Month, Day, Year): MAY 19 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

5+C

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13290
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Albert ROCKS | | | | 2. DATE OF DEATH (Month, Day, Year): May 24, 1989 | 3. TIME OF DEATH: 8:20 P M | |
| 4. SOCIAL SECURITY NUMBER: 215 18 6181 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 1, 1923 | 8. BIRTHPLACE (State or Foreign Country): Balto Md. | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | | 10c. CITY, TOWN OR LOCATION: Middle River | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 201 Wampler Rd. | | | 10f. ZIP CODE: 21220 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker | | 16b. KIND OF BUSINESS/INDUSTRY: Steel Mill | |
| 17. FATHER'S NAME (First, Middle, Last): William D. Rocks | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Showly | | | |
| 19a. INFORMANT'S NAME (Type/Print): Emma Riley, Daughter | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9757 Matzon Rd. Balto Md. 21220 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens | | 20c. LOCATION — City or Town, State: Baltimore Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave Balto Md. 21221 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of the stomach. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypotension. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Dehydration. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | N/A | ▶ 5/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mansur Khan, M.D. 9000 Franklin Square Dr. Baltimore 21237.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13291

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Leo J. Szymkowiak | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 20 / 89 | 3. TIME OF DEATH: 6:40 AM |
| 4. SOCIAL SECURITY NUMBER: 213-01-0338 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/10/16 | 8. BIRTHPLACE (State or Foreign Country): Balto, MD |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 354 Gusryan St | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: W |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WELDER | 16b. KIND OF BUSINESS/INDUSTRY: CROWN CORK &SEAL |
| 17. FATHER'S NAME (First, Middle, Last): JACOB SZYMKOWIAK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANTOINETTE MUROWSKI | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. CECELIA SZYMKOWIAK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 354 GUSRYAN ST. BALTIMORE, MARYLAND 21224 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY CROSS POLISH NATIONAL | 20c. LOCATION — City or Town, State: BALTO. MD. CO. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond A. Kaczorowski | | 22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. 21224 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Renal Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cardiac Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Staph Pneumonia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sheldon Kottkamp MD clinical Dept of Cardiology Francis Scott Key Hosp | 29c. LICENSE NUMBER: D16362 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/20/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frame, MD | | | |
| 31. DATE FILED (Month, Day, Year): MAY 24 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13292

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth May Smith (RUTH Smith)
2. DATE OF DEATH (Month, Day, Year): 5 21 89
3. TIME OF DEATH: 10:12 AM
4. SOCIAL SECURITY NUMBER: 216165664
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 8 23 22
8. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Timonium
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 45 Belfast Road
10f. ZIP CODE: 21093
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager
16b. KIND OF BUSINESS/INDUSTRY: Bakery

17. FATHER'S NAME (First, Middle, Last): Edward J. Chadima
16. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Huzzar

19a. INFORMANT'S NAME (Type/Print): Charles J. Smith, Sr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45 Belfast Road, Timonium, Md. 21093

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens
20c. LOCATION — City or Town, State: Timonium, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bryan W. Clary
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd., Timonium, Md. 21093

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CA. c BRAIN METS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Carla S. Alexander M.D.
29c. LICENSE NUMBER: D27087
29d. DATE SIGNED (Month, Day, Year): 5/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

31. DATE FILED (Month, Day, Year): MAY 24 1989
32. REGISTRAR'S SIGNATURE: Julia Dickson-Lindsay

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13293 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM SIMPSON Jr
2. DATE OF DEATH: MONTH 5 DAY 10 YEAR 89
3. TIME OF DEATH: 0800 M
4. SOCIAL SECURITY NUMBER: 215-16-5539
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 12.30.24
8. BIRTHPLACE (State or Foreign Country): SC
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN.
9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: RANDALLSTOWN
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3817 CORONADO rd
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Per Postal Service
16b. KIND OF BUSINESS/INDUSTRY: US GOVT.
17. FATHER'S NAME (First, Middle, Last): William Simpson Sr
18. MOTHER'S NAME (First, Middle, Maiden Surname): Allene Jones
19a. INFORMANT'S NAME (Type/Print): Alice Simpson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3817 Coronado RD Balto MD 21207
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD National Mem Pk
20c. LOCATION — City or Town, State: Laurel, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Marshall P Hayes
22. NAME AND ADDRESS OF FACILITY: 635 N Gilmor St MARSHALL P. HAYES F/H Baltimore, MD 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIAC ARRHYTHMIA — Approximate Interval: 0 min
DUE TO (OR AS A CONSEQUENCE OF):
b. MYOCARDIAL INFARCTION
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE, DIABETES

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD
29c. LICENSE NUMBER: D37333
29d. DATE SIGNED (Month, Day, Year): ▶ 5.10.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI, BCGH, RANDALLSTOWN.
31. DATE FILED (Month, Day, Year): MAY 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

88 13583

- 1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13294

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John Louis SAUER | | | | | 2. DATE OF DEATH: MONTH May DAY 7, YEAR 1989 | 3. TIME OF DEATH: 5:26 AM |
| 4. SOCIAL SECURITY NUMBER: 166-10-8864 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5-14-17 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1209 Fuselage Avenue | | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired-Electrician | 16b. KIND OF BUSINESS/INDUSTRY: Glenn L. Martin Co. | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): George Sauer | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Stanley |
| 19a. INFORMANT'S NAME (Type/Print): Mr. David G. Sauer | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 Hydroplane Drive Balto., Md. 21220 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leasdale Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
e. Hypoxia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Bilateral pulmonary infiltrates
DUE TO (OR AS A CONSEQUENCE OF):
c. Probable infection and adult respiratory distress syndrome
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sally Ingram MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year) ▶ 5/7/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sally Ingram, M.D. 9000 Franklin Square Dr. 21237 | | |
| 31. DATE FILED (Month, Day, Year): MAY 10 1989 | 32a. REGISTRAR'S SIGNATURE: Julie Davidson-Rohrbeck | |

10

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13295 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel Maude Sweetland
2. DATE OF DEATH: MONTH 05 DAY 02 YEAR 1989
3. TIME OF DEATH: 12 10 PM
4. SOCIAL SECURITY NUMBER: 313-20-3672
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-18-08
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Maryland Masonic Homes
9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville
9c. COUNTY OF DEATH: Balto.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Balt.
10c. CITY, TOWN OR LOCATION: Cockeysville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 300 International Circle
10f. ZIP CODE: 21030
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): mother & Home maker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Richard Spencer Day
18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Davidson
19a. INFORMANT'S NAME (Type/Print): Jean Keefer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2818 Pinewick Rd. Ellicott City MD 21043
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery
20c. LOCATION — City or Town, State: BALTO. MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Bennett, Jr.
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(e) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and dus to the ceuse(e) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul M. Lin MD
29c. LICENSE NUMBER: D25488
29d. DATE SIGNED (Month, Day, Year): ▶ 5/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): MAY 9, 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13296 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERTHA M. SEMBLY | | | 2. DATE OF DEATH (Month, Day, Year): 05 08 89 | 3. TIME OF DEATH: 9:40 AM |
| 4. SOCIAL SECURITY NUMBER: 220-20-9607 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10 26 02 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTO. |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: LUTHERVILLE | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 603 W. SEMINARY AVENUE | | 10f. ZIP CODE: 21093 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): EDWARD SEMBLY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES JORDAN | | |
| 19a. INFORMANT'S NAME (Type/Print): GLADYS E. DIXON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1803 WALBROOK AVENUE BALTO. MD 21217 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS Memorial Park | | 20c. LOCATION — City or Town, State: ARBUTUS, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jerry Harris | | 22. NAME AND ADDRESS OF FACILITY: Chestnut + Harris F.H. 1701-03 McCulloh Street | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. END STAGE RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHRONIC ATRIAL FIBRILLATION
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D33215 | ▶ 05/08/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 10 1989 | [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13297 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George H. Schmidt
2. DATE OF DEATH: MONTH 05 DAY 19 YEAR 89
3. TIME OF DEATH: 3:05 p M
4. SOCIAL SECURITY NUMBER: 215 03 7265
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/22/11
8. BIRTHPLACE (State or Foreign Country): Md

**RESIDENCE OF DECEDENT**

9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD
9c. COUNTY OF DEATH: United States
10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Rosedale
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 826 Rosedale Ave
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Totalizator
16b. KIND OF BUSINESS/INDUSTRY: Race Track
17. FATHER'S NAME (First, Middle, Last): — — Schmidt
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary —
19a. INFORMANT'S NAME (Type/Print): Madeline A. Schmidt
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 826 Rosedale Ave Rosedale Md 21237
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith
20c. LOCATION — City or Town, State: Fossville, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Curtch/Rosedale F.H. 1211 Chesaco Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Coronary Artery Disease | 10 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Myocardial infarction | Hours |
| c. DUE TO (OR AS A CONSEQUENCE OF): | Coronary Artery bypass | Hours |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) ▶ 5-20-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERG L. DRAWBAUGH St Joseph Hosp
31. DATE FILED (Month, Day, Year): MAY 22 1989
32. REGISTRAR'S SIGNATURE: Gloria Barker-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13298
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William F. SCHARF | | | | 2. DATE OF DEATH (Month, Day, Year): May 18, 1989 | 3. TIME OF DEATH: 8:11 A M |
| 4. SOCIAL SECURITY NUMBER: 215 03 4316 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 5, 1913 |
| 8. BIRTHPLACE (State or Foreign Country): Baltimore Md | | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 1462 Kent Rd. | | 10f. ZIP CODE: 21221 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Police Officer | | 16b. KIND OF BUSINESS/INDUSTRY: County Government | |
| 17. FATHER'S NAME (First, Middle, Last): Martin H. Scharf | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Gross | | | |
| 19a. INFORMANT'S NAME (Type/Print): Rose J, Balk, Daughter | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1558 Galena Rd. Balto., Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens | | 20c. LOCATION — City or Town, State: Baltimore Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Dysrhythmia — DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial Ischemia — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| P Joyce MD | | May 18, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patrick Joyce M.D. 9000 Franklin Sq. Dr. 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | Julia Davidson-Goodwin |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13299
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BRITTANY MONICA Schaefer | | | 2. DATE OF DEATH: MONTH 5 DAY 1 YEAR 89 | 3. TIME OF DEATH: 9:10 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS 10 — IF UNDER 24 HRS.: HOURS — MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-21-89 | 8. BIRTHPLACE (State or Foreign Country): Balto Md |
| 9a. FACILITY NAME (If not institution, give street and number): St Joseph's Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Balto | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore County | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5 Birsay Court | 10f. ZIP CODE: 21236 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Christopher John Schaefer | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Janice Monica Golder |
| 19a. INFORMANT'S NAME (Type/Print): Christopher J. Schaefer | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Birsay Ct. Balto. Md. 21236 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Joseph Church Cemetery | 20c. LOCATION — City or Town, State: Balto. County, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lasseter Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory failure | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Possible bronchopneumonia | 3 4-5 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malformations, 46 XY,
Possible Meckel-Gruber Syndrome

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S.C.H. Lee M.D. | 29c. LICENSE NUMBER: D0.6234 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL C.H. LEE, M.D. ST. JOSEPH Hospital, Towson, MD 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 0 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13300
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sylvia H. Sachs | | | | 2. DATE OF DEATH: MONTH 5 DAY 15 YEAR 89 | 3. TIME OF DEATH: 11:55 AM |
| 4. SOCIAL SECURITY NUMBER: 095-03-8413 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5 15 1918 | 8. BIRTHPLACE (State or Foreign Country): NY |
| 9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD | | 9c. COUNTY OF DEATH: Baltimore County | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4530 OLD COURT ROAD | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESWOMAN | 16b. KIND OF BUSINESS/INDUSTRY: KRONHEIM CO. INC. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH HABER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA UNKNOWN |
| 19a. INFORMANT'S NAME (Type/Print): SIDNEY L. SACHS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4530 OLD COURT RD. BALTIMORE, MARYLAND 21208 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREATER BALTIMORE LODGE- BALTIMORE, MD | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sydney L. Stallman | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MET. BREAST CA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carla A. Alexander MD | 29c. LICENSE NUMBER: D27087 | 29d. DATE SIGNED (Month, Day, Year) ▶ 5-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carla S. Alexander, M.D. - 2300 Dulaney Valley Rd. - Towson, MD 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers |

DHMH-16 Rev 1/89

88 13300

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13301

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LOUIS STONE | | | 2. DATE OF DEATH (Month, Day, Year): MAY 17, 1989 | 3. TIME OF DEATH: 7:15 P. M |
| 4. SOCIAL SECURITY NUMBER: 218-09-1977 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): OCT. 25, 1906 | 8. BIRTHPLACE (State or Foreign Country): POLAND |
| 9a. FACILITY NAME (If not institution, give street and number): PIKESVILLE NURSING HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 6608 EBERLE DRIVE APT. 304 | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESMAN | 16b. KIND OF BUSINESS/INDUSTRY: CLOTHES | |
| 17. FATHER'S NAME (First, Middle, Last): MAX STONE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HANNAH STEIN | |
| 19a. INFORMANT'S NAME (Type/Print): SAMUEL STONE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3406 MARYVALE RD. BALTO., MD 21207 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MIKRO KODESH BETH ISRAEL CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Lewis | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen Hettleman, MD 1777 Reisterstown Rd 21208

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davison-Landsea |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13302

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John A. Saffran Jr. | | | 2. DATE OF DEATH: MONTH 5 DAY 22 YEAR 89 | 3. TIME OF DEATH: 6:45 a M | |
| 4. SOCIAL SECURITY NUMBER: 220-56-0641 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 37 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-5-52 | 8. BIRTHPLACE (State or Foreign Country): Maryland | |
| 9a. FACILITY NAME (If not institution, give street and number): 3816 McDowell Lane | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore County | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 3816 McDowell Lane | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clergy | | 16b. KIND OF BUSINESS/INDUSTRY: Church | |
| 17. FATHER'S NAME (First, Middle, Last): John A. Saffran Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Reigle | | | |
| 19a. INFORMANT'S NAME (Type/Print): Diane M. Saffran | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3816 McDowell Lane Baltimore, Maryland 21227 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jerome Franciewski | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home 4001 Ritchie Hwy. Baltimore, Md. 21225 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Vascular collapse | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Liver failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Cholangiocarcinoma | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Catherine A. Nord MD | BN-124-95-88 | ▶ 5-23-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): The Johns Hopkins Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 26 1989 | Julia Davidson-Landrum |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13303

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sherman O. Shaffer | | | | 2. DATE OF DEATH (Month, Day, Year): 05 23 89 | | 3. TIME OF DEATH: 8:45 a M |
| 4. SOCIAL SECURITY NUMBER: 216-22-1646 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 96 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Mar. 12 1893 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Reisterstown | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 12020 Reisterstown Road | | 10f. ZIP CODE: 21136 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | 16b. KIND OF BUSINESS/INDUSTRY: Agriculture |
| 17. FATHER'S NAME (First, Middle, Last): Unknown by informant | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown by informant | |
| 19a. INFORMANT'S NAME (Type/Print): Hilda G. Dorn | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14226 Westside Phoenix Road, Phoenix, Md. 21131 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. John's Evangelical Luth. Ch. | 20c. LOCATION — City or Town, State: Cem. Carroll County, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martin D. Lawson | | 22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Poor Myocardial Compliance
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Status Post Right Hip Surgery

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Bassam Rizk M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Bassam Rizk, M.D. G.B.M.C.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

89 13304

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| Matthew | Jay | Sammons | 5 / 21 / 89 | 12:50 pM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-86-3993 | 1 [X] M 2 [ ] F | 27 YRS. | | | April 14, 1962 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1313 Chesapeake Avenue | Bowleys Quarters | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Baltimore | Bowleys Quarters | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1313 Chesapeake Ave. | 21220 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th | | | Truck Washers of America |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Carl Fischer | Sylvia Woods |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Sylvia Fischer | 3812 New Section Road Balto. Md.21220 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | Holly Hill Cemetery | Balto. Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Connelly Funeral Home | ConnellyFuneralHome 300MaceAve.21221 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Contact shotgun wound to the chest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX [X] YES 2 [ ] NO | XX [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |
|---|---|
| XX [X] YES 2 [ ] NO | |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 5/21/89 | M | 1 [ ] YES 2 [X] NO | Subject shot self |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| HOME | Balto, Md. 1313 Chesapeake Avenue Balto Co. |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 5/22/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James A. Kaplan, M.D., 111 Penn , Baltimore, Maryland 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 25 1989 | [signature] |

DHMH-16 Rev 1/89

89 13305

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed ... by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Robert Lee SMITH | | 2. DATE OF DEATH (Month, Day, Year): May 22, 1989 | 3. TIME OF DEATH: 4:00 AM |
| 4. SOCIAL SECURITY NUMBER: 162-09-8823 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 4 1911 |
| 8. BIRTHPLACE (State or Foreign Country): PA. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | 9c. COUNTY OF DEATH: Baltimore County | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: MiddleRiver | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 9 Helocopter Drive | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: Martins | |
| 17. FATHER'S NAME (First, Middle, Last): Verner Smith | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Jesse Lord | | |
| 19a. INFORMANT'S NAME (Type/Print): Helen C. Smith | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Helocopter Drive BAltimore MAryland | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process Inc. | 20c. LOCATION — City or Town, State: Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MaceAve. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Bradycardia with hypertension
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Ischemic heart disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic obstructive pulmonary disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen L. Kinney MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 5-22-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. Kinney, M.D. 9000 Franklin Square Drive 21237 | | |
| 31. DATE FILED (Month, Day, Year): MAY 23 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randazzo | |

DHMH-16 Rev 1/89

88 13302

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13306
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): William J. SMITH | | | | 2. DATE OF DEATH (Month, Day, Year): May 19 1989 | 3. TIME OF DEATH: 2:36 a M |
| 4. SOCIAL SECURITY NUMBER: 219-50-3729 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 42 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan 30 1947 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 512 Virginia Ave. | | 10f. ZIP CODE: 21221 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Inspector | | 16b. KIND OF BUSINESS/INDUSTRY: Martin Marietta | |
| 17. FATHER'S NAME (First, Middle, Last): William C. Smith | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Edell | | | |
| 19a. INFORMANT'S NAME (Type/Print): Ellen Smith | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 512 Virginia Ave. Balto. Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State: Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MAceAve. 21221 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE MYOCARDIAL INFARCTION ~2h.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Roy W. Cragway Jr M.D. | D28466 | ▶ 5/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Roy W. Cragway, M.D. 9000 Franklin Square Dr, Baltimore MD 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 23 1989 | Julia Dodson-Rudasa |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13307
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Alda Bernadette SCHLIMM | | 2. DATE OF DEATH (Month, Day, Year): May 13, 1989 | 3. TIME OF DEATH: 7:20a. M |
| 4. SOCIAL SECURITY NUMBER: 218-26-0650 | 5. SEX: 1 ☐ M 2 ☒ F | 8. AGE (In yrs. last birthday): 61 yrs. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): March 9, 1928 | 8. BIRTHPLACE (State or Foreign Country): Pa. | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore County | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 9506 Perry Hall Blvd. | 10f. ZIP CODE: 21236 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | 16b. KIND OF BUSINESS/INDUSTRY: Shoe Store | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Anderson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Hagan | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary P. Anderson - Sister | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9506 Perry Hall Blvd, Balto, Md. 21236 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Mem. Gardens | 20c. LOCATION — City or Town, State: Churchville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home, Inc. 9705 Belair Rd, Balto, Md. 21236 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adenocarcinoma of the Rectum | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Alfred L. Covington MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 5/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alfred Covington, M.D. 9000 Franklin Square Drive, 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 15 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13308

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Stratmeyer
2. DATE OF DEATH (Month, Day, Year): May 17 1989
3. TIME OF DEATH: 7:30P M
4. SOCIAL SECURITY NUMBER: 218-26-3747
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 5 1930
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 2923 Willoughby Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore County

**RESIDENCE OF DECEDENT**

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2923 Willoughby Rd.
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): n/a — College (1-4 or 5+): n/a
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Insurance Agent
16b. KIND OF BUSINESS/INDUSTRY: Insurance
17. FATHER'S NAME (First, Middle, Last): John Stratmeyer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie B. Manning
19a. INFORMANT'S NAME (Type/Print): Edna Stratmeyer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2923 Willoughby Rd. Balto. Md. 21234
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Colonic Adenocarcinoma | 7yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Marshall A. Levine
29c. LICENSE NUMBER: D17873
29d. DATE SIGNED (Month, Day, Year): ▶ 5/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marshall Levine, M. D. 4000 Old Court Rd., Suite 306
31. DATE FILED (Month, Day, Year): MAY 19 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

88 13308

89 13309

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): IRVIN / Irvin Kenwood Schisler / K. Schisler | | | 2. DATE OF DEATH (Month, Day, Year): 5-10-89 | 3. TIME OF DEATH: 0548 AM |
| 4. SOCIAL SECURITY NUMBER: 218-01-4588 | 5. SEX: 1 X M 2 ☐ F | 8. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8 26 15 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | 9c. COUNTY OF DEATH: Baltimore | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 1501 Kent Ave. | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plant Supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Rubber Plant |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Irvin E. Schisler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Snyder |
| 19a. INFORMANT'S NAME (Type/Print): Arletta L. Schisler | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1501 Kent Avenue, Baltimore, MD 21207 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ S. M Loewner | 22. NAME AND ADDRESS OF FACILITY: MacNabb Funeral Home, Catonsville, MD 21228 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Anderoseptal Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Multiple Sclerosis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 26d. DESCRIBE HOW INJURY OCCURED | | | |
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara Socha, M.D. | 29c. LICENSE NUMBER: D35609 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5 10 89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA Socha 5401 Old Court Rd., Randallstown, MD 21133 | | | |
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Dickson-Landeo | | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13310

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles Roger Smith Jr. | | | | | 2. DATE OF DEATH (Month, Day, Year): 5-5-89 | | 3. TIME OF DEATH: 7:30AM M |
| 4. SOCIAL SECURITY NUMBER: 220-66-0232 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 34 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-8-54 | | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 2510 Peck Avenue | | | 9b. CITY, TOWN OR LOCATION OF DEATH: EDGEMERE | | | 9c. COUNTY OF DEATH: Baltimore County | |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: EDGEMERE | | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 2510 PECK AVENUE | | | 10f. ZIP CODE: 21219 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FORKLIFT DRIVER | | | 16b. KIND OF BUSINESS/INDUSTRY: DAPP, INC. | | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES R. SMITH, SR. | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARLENE UPDEGRAFF | | |
| 19a. INFORMANT'S NAME (Type/Print): MARLENE WAGNER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2510 PECK AVENUE BALTIMORE, MARYLAND 21219 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 5-8-89 | | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gregory E. Ruck | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Obesity

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home [X] 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | 5-5-89 |

30a. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 8 - 1989 | Julia Kirkpatrick Randall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13311

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RAFAEL RODRIGUEZ | | | 2. DATE OF DEATH: MONTH MAY DAY 1, YEAR 1989 | 3. TIME OF DEATH: 8:23 A. M |
| 4. SOCIAL SECURITY NUMBER: 579-56-9475 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11/6/27 | 8. BIRTHPLACE (State or Foreign Country): S. AMERICA COLUMBIA |
| 9a. FACILITY NAME (If not institution, give street and number): 2117 CHANTILLA ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2117 CHANTILLA ROAD | | 10f. ZIP CODE: 21228 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOCTOR | | 16b. KIND OF BUSINESS/INDUSTRY: HEALTH CARE |
| 17. FATHER'S NAME (First, Middle, Last): MARCO RODRIGUEZ | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DELFINA BLANCO | | |
| 19a. INFORMANT'S NAME (Type/Print): MARIA RODRIGUEZ | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2117 CHANTILLA ROAD CATONSVILLE, MD 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTVIEW CREMATORY | | 20c. LOCATION — City or Town, State: WESTVIEW, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE, CATONSVILLE, MD 21228 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Adenocarcinoma of Lung | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D18587 | 29d. DATE SIGNED (Month, Day, Year): 5/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL GORMLEY M.D. 900 CATON AVENUE ST. AGNES HOSPITAL 3rd FLOOR TOWER BLDG, BALTIMORE, MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

ONMN-16 Rev 1/89

89 13312

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13312

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Andrew Louis Syor | | | 2. DATE OF DEATH (Month, Day, Year): May 1 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 058 01 7633 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 09-20-16 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): 14 Right Wing Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Middle River 21220 | | 9c. COUNTY OF DEATH: Baltimore County |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Middle River 21220 | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 14 Right Wing Drive | | 10f. ZIP CODE: 21220 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War 2 | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th Grade; College (1-4 or 5+): 4 Years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Purchaser | 16b. KIND OF BUSINESS/INDUSTRY: United States Government | | |
| 17. FATHER'S NAME (First, Middle, Last): Louis Syor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna O'Connor | | |
| 19a. INFORMANT'S NAME (Type/Print): Myrtie Syor (wife) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 Right Wing Drive Baltimore Maryland 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Memorial Gardens | 20c. LOCATION — City or Town, State: Baltimore Co., Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home P.A. 21221 1407 Old Eastern Ave. Baltimore Maryland | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest.- | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Convulsive disorder. | 1984 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Carotid bruit | Nov 88 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None.-

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D

29c. LICENSE NUMBER: D02022

29d. DATE SIGNED (Month, Day, Year): ▶ 5-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Leopoldo Gruss M.D. 405 Stemmers Run Rd. Balto MD 21221

31. DATE FILED (Month, Day, Year): MAY 5 - 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMH-16 Rev 1/89

89 13313

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH PAUL SULLIVAN | | | 2. DATE OF DEATH: MONTH 5 DAY 5 YEAR 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215-34-6625 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 50 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Mar 19 1939 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 63 A Oak Grove Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Middle River | | 9c. COUNTY OF DEATH: BAltimore |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Middle River | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 63 A Oak Grove Road | | 10f. ZIP CODE: 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): Paul A. Sullivan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Juanita E. Rook | | |
| 19a. INFORMANT'S NAME (Type/Print): Debbie Lesko | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 903 Essex Square BAlto. Md. 21221 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Rossville Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAVe.21221 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute gastrointestinal hemorrhage
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic alcoholism
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 1 [ ] YES 2 [ ] NO | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| J. Crossan O'Donovan | D07632 | ▶ 5/7/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. CROSSAN O'DONOVAN, 2112 DUNDALK AVE., BALT., MD 21222

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 8 1989 | Julia Davidson-Reddick |

DHMH-16 Rev 1/89

88 13313

Item#15,28f per FH FilmG652 6/5/89 fj
Add.InfoFilmG650 4/11/89 kam

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13314 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joanna Lynn Sidor | | | | 2. DATE OF DEATH (Month, Day, Year): 3-30-89 | 3. TIME OF DEATH: 7:54AM M |
| 4. SOCIAL SECURITY NUMBER: 244-33-7875 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 22 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-22-1966 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Josephs Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 919 Dalton Avenue | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ~~10 years~~ 11yrs; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home maker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Stephen Alphones Sidor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dora E. Baca | |
| 19a. INFORMANT'S NAME (Type/Print): Dora E. Francum | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1517 Barcose St. SW, Lenoir, N.C. 28645 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery 4-3-1989 | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott P. Davidson | 22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Balto., Md. 21222 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute cocaine intoxication

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 3/30/89 | 28b. TIME OF INJURY: unk M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| 28d. DESCRIBE HOW INJURY OCCURED: unknown | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home, | 8509 David Ave. Balto, Md. 2123 ~~919 Dalton Ave, Balto., Md.~~ | |

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 3-30-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. | 111 Penn Street, Baltimore, MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): APR 4 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 13315

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rose Geraldine Smith | | | 2. DATE OF DEATH (Month, Day, Year): 5 5 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 212-20-8414 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6 25 1927 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 8a. FACILITY NAME (If not institution, give street and number): 7911 Crisford Place Apt. G | | 9b. CITY, TOWN OR LOCATION OF DEATH: Pikesville | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Pikesville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7911 Crisford Place Apt. G | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY? United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Receptionist | 16b. KIND OF BUSINESS/INDUSTRY: N. Charles General Hosp. | |
| 17. FATHER'S NAME (First, Middle, Last): John B. Lucido | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Shepherd | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Steven Smith | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4835 Shookstown Road Frederick, MD 21701 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Pikesville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert J. Evans | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiac Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Atherosclerotic Coronary Artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert J. Evans | 29c. LICENSE NUMBER: D 21118 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/8/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Jeffrey Quintiveros 4000 Old Court Rd. Baltimore 21208

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |

DHMH-16 Rev 1/89

68 13312

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13316
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Tiffany SMITH
2. DATE OF DEATH (Month, Day, Year): May 4, 1989
3. TIME OF DEATH: 10:50PM M
4. SOCIAL SECURITY NUMBER: N/A
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS 0 DAYS 0 — IF UNDER 24 HRS.: HOURS 0 MIN. 43
7. DATE OF BIRTH (Month, Day, Year): May 4, 1989
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore Co.

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Pasadena
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8566 Skipjack Place
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: XX
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Infant — College (1-4 or 6+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Glenn Richard Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Catherine Haislip
19a. INFORMANT'S NAME (Type/Print): Glenn Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8566 Skip Jack Place Pasadena, Maryland 21122
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Richard Gonce
22. NAME AND ADDRESS OF FACILITY: George J. Gonce Funeral Home, P.A. 4001 Ritchie Hgwy., Baltimore, MD 21225

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Premature Birth
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Complex Congenital Malformation
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Howard M. Lederman MD
29c. LICENSE NUMBER: D30267
29d. DATE SIGNED (Month, Day, Year): ▶ 5/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Howard Lederman MD 9000 Franklin Square Drive Balto Md 21237
31. DATE FILED (Month, Day, Year): MAY 8 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13317

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): REGINA SAMET | | | | | 2. DATE OF DEATH (Month, Day, Year): MAY 2 1989 | 3. TIME OF DEATH: 3:00 A M |
| 4. SOCIAL SECURITY NUMBER: 102-10-0859 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): DEC. 5,1895 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): PIKESVILLE NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE | | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY,MD. | | | | 10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3601 FORDS LANE BALTIMORE,MD. | | 10f. ZIP CODE: 21215 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 GRADE; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): ABRAHAM HIMOWITZ | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE KREFETZ | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. ELIZABETH FRANK | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4410 EVA MAY ROAD APT T-2 BALTO.,MD. 21215 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON CEMETERY | | | 20c. LOCATION — City or Town, State: BALTO.,MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jay Levin | | | | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON AND BROS.,INC. 6610 REISTERSTOWN ROAD BALTO.,MD. 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Dementia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 XX NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES XX NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | | | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Claudia Levin MD | D27075 | ▶ 5-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Claudia Levin 10219 Dolfield Rd Owings Mills MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 5 MAY 8 1989 | 2117 |

DHMH-16 Rev 1/89

89 13318

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Daniel Clyde Smith | | | | 2. DATE OF DEATH (Month, Day, Year): 5-9-89 | 3. TIME OF DEATH: 5:50PM M |
| 4. SOCIAL SECURITY NUMBER: 217-78-5180 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 30 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | | 7. DATE OF BIRTH (Month, Day, Year): 12-1-1958 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Bethlehem Steel One Pier | | 9b. CITY, TOWN OR LOCATION OF DEATH: Sparrows Point | | 9c. COUNTY OF DEATH: Baltimore County | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Md | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: MIDDLE RIVER | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 7 Dogwood Drive | | 10f. ZIP CODE: 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 Th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND OF BUSINESS/INDUSTRY: BALTO. CO., UTILITY | |
| 17. FATHER'S NAME (First, Middle, Last): Richard L. Smith | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Gordon | |
| 19a. INFORMANT'S NAME (Type/Print): Betty Smith | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8519 A Heathrow Ct. Balto. Md. 21236 | | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Security Process | | 20c. LOCATION — City or Town, State: Balto. Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Connelly F.H. 300 Mace Ave | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Drowning | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Phencyclidine (PCP) Intoxication

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): water

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 4-29-89 | 8:45A M | 1 [ ] YES 2 [X] | Subject drowned |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): water

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Chesapeake Bay/Worton Pt.Kent Co.,MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle M.D.

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year) ▶ 5-10-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle,M.D. 111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year): MAY 12 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Landeck

DHMH-16 Rev 1/89

88 13310

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13319 REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): AUDREY M. SEAL | | | | | | 2. DATE OF DEATH: MONTH 05 DAY 10 YEAR 89 | 3. TIME OF DEATH: 1:30 P M |
| 4. SOCIAL SECURITY NUMBER: 214-24-8780 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | 7. DATE OF BIRTH (Month, Day, Year): JUNE 5, 1923 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 1222 WHITE MILLS ROAD | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1222 WHITE MILLS ROAD | | | | 10f. ZIP CODE: 21228 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALES/BUYER | | | 16b. KIND OF BUSINESS/INDUSTRY: RETAIL | | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM T. COWAN SR. | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELSIE L. KALTER | | |
| 19a. INFORMANT'S NAME (Type/Print): CAROL McAULAY | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1222 WHITE MILLS ROAD CATONSVILLE, MD 21228 | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY | | 20c. LOCATION — City or Town, State: PIKESVILLE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | | | 22. NAME AND ADDRESS OF FACILITY: LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE. CATONSVILLE,MD 21228 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Lung

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Nelson McCoy MD

29c. LICENSE NUMBER: D 06893

29d. DATE SIGNED (Month, Day, Year): May 10, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 413 Commonwealth Ave Baltimore, Md 21228

31. DATE FILED (Month, Day, Year): MAY 11 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Landers

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88 13318

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13320

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY J. SILHAN
2. DATE OF DEATH: MONTH 05 DAY 07 YEAR 89
3. TIME OF DEATH: 10 A M
4. SOCIAL SECURITY NUMBER: 217-34-2672
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): OCT. 20, 1903
8. BIRTHPLACE (State or Foreign Country): BALTO. MD.
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD.
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5917 SHADY SPRING ROAD
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced — X
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES X
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: AT HOME
17. FATHER'S NAME (First, Middle, Last): FRANK FUKA
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA PETR
19a. INFORMANT'S NAME (Type/Print): THOMAS SILHAN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5917 SHADY SPRING ROAD BALTO. MD. 21237
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faitj Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John E. Dolan
22. NAME AND ADDRESS OF FACILITY: DIPPEL FUNERAL HOME, INC. 7110 BELAIR ROAD BALTIMORE, MD. 21206

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such ae cerdiac or reapiratory arreat, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Acute and Subacute Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. Sergio Cassanego MD
29c. LICENSE NUMBER: D29770
29d. DATE SIGNED (Month, Day, Year): ▶ 5-7-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. Sergio Cassanego, M.D., 6304 Kenwood Ave., 21237
31. DATE FILED (Month, Day, Year): MAY 9, 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMN-16 Rev 1/89

88 13350

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13321

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Walter Linwood Sawyer
2. DATE OF DEATH (Month, Day, Year): May 4 1989
3. TIME OF DEATH: 7:50 A.M.
4. SOCIAL SECURITY NUMBER: 216-34-7170
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 8, 1933
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Home 111 West Road
9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Maryland
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1 Alabama Court
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 6+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Manager
16b. KIND OF BUSINESS/INDUSTRY: Insurance
17. FATHER'S NAME (First, Middle, Last): Walter Melton Sawyer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hilda Soles
19a. INFORMANT'S NAME (Type/Print): Linda J. Sawyer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Alabama Court, Towson, Md. 21204
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Woodlawn, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martin D. Lawson
22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lymphoma | 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Philip Konits
29c. LICENSE NUMBER: D24321
29d. DATE SIGNED (Month, Day, Year): 5/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Phillip Konits, M.D., 100 Owings Court Suite 2, Reisterstown, Md. 21136
31. DATE FILED (Month, Day, Year): MAY 9 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13322
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Wilson Woodrow Sennett | | | | 2. DATE OF DEATH (Month, Day, Year): 05 12 89 | 3. TIME OF DEATH: 9:00 A. M |
| 4. SOCIAL SECURITY NUMBER: 213-09-2541 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-25-12 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): 4017 Bay Drive | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bowleys Quarters | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Bowleys Quarters | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4017 Bay Drive | | 10f. ZIP CODE: 21220 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator | 16b. KIND OF BUSINESS/INDUSTRY: Bathlehem Steel | | | |
| 17. FATHER'S NAME (First, Middle, Last): John Sennett | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Sparks | | | |
| 19a. INFORMANT'S NAME (Type/Print): Richard W. Sennett | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4017 Bay Drive Balto., Md. 21220 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State: Eastwood, Balto. Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Possible Aorta M.F | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Asym. with Severe Aortic Stenosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

a. Severe C-C-P.
b.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D17148 | ▶ 5-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | |

DHMH-16 Rev 1/89

88 13355

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13323

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

6

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HANS SANNESS
2. DATE OF DEATH — MONTH: 5 DAY: 19 YEAR: 89
3. TIME OF DEATH: 405 M
4. SOCIAL SECURITY NUMBER: 217-09-1588A
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/8/04
8. BIRTHPLACE (State or Foreign Country): NORWAY
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GEN. HOSP.
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 16 BITTERROOT CT. APT. E.
10f. ZIP CODE: 21117
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: CAUC.
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNK — College (1-4 or 5+): UNK
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMAN
16b. KIND OF BUSINESS/INDUSTRY: MERCHANT MARINE
17. FATHER'S NAME (First, Middle, Last): UNKNOWN
16. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN
19a. INFORMANT'S NAME (Type/Print): ANNA SANNESS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16 BITTERROOT CT APT. E. BALTIMORE MD 21117
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREENMOUNT CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bernard Dabrowski Jr.
22. NAME AND ADDRESS OF FACILITY: B. DABROWSKI & SON 2818 E. BALTIMORE ST. BALTIMORE MD 21224

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetione thet ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. RESPIRATORY FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

c. PULMONARY FIBROSIS

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.: POSSIBLE PERFORATED VISCUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD.
29c. LICENSE NUMBER: D19502
29d. DATE SIGNED (Month, Day, Year): ▶ 5-19-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ORLANDO B. CONANAN MD BCGH-RANDALLSTOWN MD. 21133
31. DATE FILED (Month, Day, Year): MAY 30 '89
32. REGISTRAR'S SIGNATURE: Lelia Davidson-Randall

DHMH-16 Rev 1/89

88 13353

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13324 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jean Singley | | | | | 2. DATE OF DEATH (Month, Day, Year): May 14, 1989 | | 3. TIME OF DEATH: Est. 7:45 P M |
| 4. SOCIAL SECURITY NUMBER: 165-20-8150 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Nov. 2, 1925 | | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): 1906 Codd Ave. | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: West Inverness, Md. | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | | | | 10c. CITY, TOWN OR LOCATION: West Inverness, Md. | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1906 Codd Ave. Baltimore Co., Maryland | | | | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 0 | | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator | | 16b. KIND OF BUSINESS/INDUSTRY: Plastics |
| 17. FATHER'S NAME (First, Middle, Last): James Bredbenner | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Leighow | | |
| 19a. INFORMANT'S NAME (Type/Print): Doreen Jeffries | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1906 Codd Ave. Balto. Co., Maryland 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond A. Weber / Raymond A. Weber (Secy.) | | | | | 22. NAME AND ADDRESS OF FACILITY: George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of Lung. (Small cell) DUE TO (OR AS A CONSEQUENCE OF): | 15 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Dis.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Nelson McKay M.D. | D06893 | ▶ May 15, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Nelson Mckay M.D. 413 Commonwealth Ave. Balto. Md. 21228

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 15 1989 | Julia Davidson-Landers |

DHMH-16 Rev 1/89

88 1335f

89 13325

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elizabeth C. Simmons | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 14 / 89 | | 3. TIME OF DEATH: 12 55 A M |
| 4. SOCIAL SECURITY NUMBER: 216 30 5014 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/2/04 | | 8. BIRTHPLACE (State or Foreign Country): CANADA |
| 9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3110 HARVIEW AVE. | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5 +): — | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK | 16b. KIND OF BUSINESS/INDUSTRY: SAVINGS BANK OF BALTIMORE | |
| 17. FATHER'S NAME (First, Middle, Last): THOMAS CAMPBELL | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CHRISTINE BELL CAMPBELL | |
| 19a. INFORMANT'S NAME (Type/Print): -FAMILY RECORDS- | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEM. PARK | 20c. LOCATION — City or Town, State: PARKVILLE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. Mary L. Gain | | 22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL 8800 HARFORD RD. PARKVILLE | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Colon Cancer c Liver Metastasis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carla A Alexander MD | 29c. LICENSE NUMBER: D27087 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 18 1989 Julia | 32. REGISTRAR'S SIGNATURE: Davidson-Kendall |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13326
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Catherine Steinbach — CATHERINE SCHOTTLER STEINBACH
**2. DATE OF DEATH** Month: 5 Day: 7 Year: 89
**3. TIME OF DEATH**: 8:15 M
**4. SOCIAL SECURITY NUMBER**: 217-36-2608
**5. SEX**: 1 ☐ M 2 ☒ F
**6. AGE** (In yrs. last birthday): 70 70 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.
**7. DATE OF BIRTH** (Month, Day, Year): 2-9-19
**8. BIRTHPLACE** (State or Foreign Country): Maryland
**9a. FACILITY NAME** (If not institution, give street and number): Saint Joseph Hospital
**9b. CITY, TOWN OR LOCATION OF DEATH**: Towson, MD.
**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland
**10b. COUNTY**: Baltimore
**10c. CITY, TOWN OR LOCATION**: Baltimore
**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO
**10e. STREET AND NUMBER**: 208 Blenheim Road
**10f. ZIP CODE**: 21212
**10g. CITIZEN OF WHAT COUNTRY?**: USA
**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
**14. RACE — American Indian, Black, White, etc.** Specify: White
**15. DECEDENT'S EDUCATION** (Specify only highest grade completed) — Elementary/Secondary (0-12); College (1-4 or 8+)
**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Teacher
**16b. KIND OF BUSINESS/INDUSTRY**: Balto City
**17. FATHER'S NAME** (First, Middle, Last): Franz Frederick Schottler
**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Ottilie Sohl
**19a. INFORMANT'S NAME** (Type/Print): Christine S. Gibson
**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1502 Cranwell Rd. Lutherville, Md. 21093
**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Loudon Park
**20c. LOCATION — City or Town, State**: Baltimore Md.
**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Dennis Stephen Kracke
**22. NAME AND ADDRESS OF FACILITY**: Mitchell-Wiedefeld 6500 York Rd 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary Arrest | 15 min. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cirrhosis | 5 yr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO
**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO
**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO
**26. PLACE OF DEATH** (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
**28a. DATE OF INJURY** (Month, Day, Year)
**28b. TIME OF INJURY** M
**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO
**28d. DESCRIBE HOW INJURY OCCURED**
**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)
**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: James Parham MD
**29c. LICENSE NUMBER**: D34084
**29d. DATE SIGNED** (Month, Day, Year) ▶ 5-7-89
**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): St. Joseph's Hospital Baltimore MD 21204
**31. DATE FILED** (Month, Day, Year): MAY 9 1989
**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

OHMH-18 Rev 1/89

88 13359

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13327
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| DORIS | R | SCHIELDKNECHT | 05 / 21 / 89 | 12:45 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212 44 0009 | 1 ☐ M 2 ☒ F | 76 YRS. | | | 02 27 1913 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| GREATER BALTO MEDICAL CENTER | BALTIMORE, MARYLAND | BALTO CO |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | TOWSON | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1039 DONNINGTON CIRCLE | 21204 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 Yrs | | Housemother | Md. General Hospital |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Charles Cleaver | Lorraine Evans |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lorraine Schieldknecht | 1039 Donnington Cir. Towson, Md. 21204 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Rose Hill Cemetery | Hagerstown, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Thomas A. Smith | Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. EMBOLIC CVA | 11 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PAROXYSMAL ATRIAL FIBRILLATION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| RICHARD WILDER, M.D Richard Wilder, M.D. | | ▶ 05 21 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Richard Wilder M.D. G.B.M.C.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 24 1989 | Julia Gordon-Rudasill |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13328
REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Raymond Kevil STONE | | | 2. DATE OF DEATH (Month, Day, Year): May 24, 1989 | 3. TIME OF DEATH: 10AM M |
| 4. SOCIAL SECURITY NUMBER: 223-28-0088 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept.12,1920 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: BAltimore | 10c. CITY, TOWN OR LOCATION: Middle River | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1112 Stephen Drive | 10f. ZIP CODE: 21220 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWll | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrican | 16b. KIND OF BUSINESS/INDUSTRY: Heating &Air Conditioning |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Cyril Day Stone | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Carter |
| 19a. INFORMANT'S NAME (Type/Print): Anna Marie Stone | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1112 Stephen Drive Balto. Md. 21220 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Belair Memorial Cemetery | 20c. LOCATION — City or Town, State: Belair MAryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: ConnellyFuneralHome 300MAceAve. 21221 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Asystole
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Anoxic Encepholopathy
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) [X] |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: P Joyce | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): MAY 24, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patrick Joyce, M.D. 9000 Franklin Sq, Dr. 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasa |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1, 2, 3 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 13358

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13329
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John Strelec, Sr | | | 2. DATE OF DEATH (Month, Day, Year): 05/ 31/ 1989 | 3. TIME OF DEATH: 8:20 A. M |
| 4. SOCIAL SECURITY NUMBER: 124-46-1053 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/21/29 | 8. BIRTHPLACE (State or Foreign Country): CZECHOSLOVAKIA |
| 9a. FACILITY NAME (If not institution, give street and number): G.B.M.C. 6701 N. CHARLES ST, | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD 21204 | | 9c. COUNTY OF DEATH: BALTIMORE |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: 319-L LIMESTONE VALLEY DR COCKEYSVILLE | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 319-L LIMESTONE VALLEY DR, | | 10f. ZIP CODE: 21030 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12YEARS; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MECHANIC | | 16b. KIND OF BUSINESS/INDUSTRY: MONTGOMERY WARD |
| 17. FATHER'S NAME (First, Middle, Last): JURAJ STRELEC | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GIZELLA MIKOLASIK | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. ZLATICA STRELEC | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 319 LIMESTONE VALLEY DR. APT. L COCKEYSVILLE 21030 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY | | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond K. Kaczorowski | | 22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 21224 2525 FLEET STREET BALTIMORE, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Congestive heart failure | ~two years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Cardiomyopathy of uncertain etiology | ~two years |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic lymphocytic leukemia/lymphoma; Pneumoconiosis

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ian K. Stepian MD | 29c. LICENSE NUMBER: D33231 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ian K. Stepian MD 1407 York Rd Ste 305, Lutherville MD 21093 | | |
| 31. DATE FILED (Month, Day, Year): JUN 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

08 1335a

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13330

DIVISION OF VITAL RECORDS, P.O. BOX 131 BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Wilkie Reid Smith

**2. DATE OF DEATH** (Month, Day, Year): May 13, 1989

**3. TIME OF DEATH**: 10:30 AM

**4. SOCIAL SECURITY NUMBER**: 173-14-0162

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 69 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): June 16, 1919

**8. BIRTHPLACE** (State or Foreign Country): Pennsylvania

**9a. FACILITY NAME** (If not institution, give street and number): 8402 Charles Valley Ct. Apt. F

**9b. CITY, TOWN OR LOCATION OF DEATH**: Towson

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Towson

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 8402 Charles Valley Court Apt. F

**10f. ZIP CODE**: 21204

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): District Court Clerk

**16b. KIND OF BUSINESS/INDUSTRY**: Judicial

**17. FATHER'S NAME** (First, Middle, Last): Ralph Arthur Smith

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Helen Brewer

**19a. INFORMANT'S NAME** (Type/Print): Roberta L. Millner

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2230 Springlake Drive, Timonium, Md. 21093

**20a. METHOD OF DISPOSITION**: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Westview Crematory

**20c. LOCATION — City or Town, State**: Catonsville, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Martin D. Lawson

**22. NAME AND ADDRESS OF FACILITY**: Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd., Timonium, Md. 21093

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction — Sudden

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ASCVD with Coronary Insuff — 5± yrs

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [ ] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Charles F. O'Donnell

**29c. LICENSE NUMBER**: D-09383

**29d. DATE SIGNED** (Month, Day, Year): May 13, 1989

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Charles F. O'Donnell MD 7501 York Rd Towson 21204

25

**31. DATE FILED** (Month, Day, Year): MAY 17 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randazzo

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13331

10

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CARL H. SCHROEDER | | | | | 2. DATE OF DEATH: MONTH 5 DAY 18 YEAR 1989 | 3. TIME OF DEATH: 525 P M | |
| 4. SOCIAL SECURITY NUMBER: 212-05-4819 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11/3/01 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND | |
| 9a. FACILITY NAME (If not institution, give street and number): 3417 GAITHER RD. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: RANDALLSTOWN | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | | |
| 10e. STREET AND NUMBER: 3417 GAITHER RD. | | | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR | | 16b. KIND OF BUSINESS/INDUSTRY: BALTO. GAS & ELECTRIC | | |
| 17. FATHER'S NAME (First, Middle, Last): ALBERT SCHROEDER | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA NEUMANN | | | | |
| 19a. INFORMANT'S NAME (Type/Print): VIOLA COOPER | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5630 GLEN FALLS ROAD, REISTERSTOWN, MARYLAND 21136 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY | | 20c. LOCATION — City or Town, State: WOODLAWN, MD. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | | 22. NAME AND ADDRESS OF FACILITY: 1630 EDMONDSON AVE. CATONSVILLE, MD. 21228 LEROY M. & RUSSELL C. WITZKE FUNERAL HOME | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| E. P. Williamson M.D. | D11171 | ▶ 5/18/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. P. WILLIAMSON MD - 5550 BALTO NAT'L PK CATONSVILLE 21228 MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 22 1989 | Julia Davidson-Landers |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 13331

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13332

DIVISION OF VITAL RECORDS, P.O. BOX 13[illegible], BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Maria Skybyk
2. DATE OF DEATH: MONTH 5 DAY 14 YEAR 89
3. TIME OF DEATH: 5[illegible]0 P M
4. SOCIAL SECURITY NUMBER: 215-30-4374
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-21-22
8. BIRTHPLACE (State or Foreign Country): Poland
- 9a. FACILITY NAME (If not institution, give street and number): Meridan N. Home, 8710 Emge Rd.
- 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. Md.21234
- 9c. COUNTY OF DEATH: Baltimore Co.

RESIDENCE OF DECEDENT

- 10a. STATE: Md.
- 10b. COUNTY: Harford
- 10c. CITY, TOWN OR LOCATION: Street, Md.
- 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
- 10e. STREET AND NUMBER: 3161 Tucker Rd.
- 10f. ZIP CODE: 21154
- 10g. CITIZEN OF WHAT COUNTRY?: Poland
- 11. MARITAL STATUS: separated (1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced)
- 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
- 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
- 14. RACE — American Indian, Black, White, etc. Specify: white
- 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 yrs. College (1-4 or 5+):
- 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House keeper Rtd.
- 16b. KIND OF BUSINESS/INDUSTRY: Self employed
- 17. FATHER'S NAME (First, Middle, Last): John Kmetyk
- 18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Dobrovulska
- 19a. INFORMANT'S NAME (Type/Print): Mrs. Jessica L. Wilson
- 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3161 Tucker Rd. Street, Md. 21154
- 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
- 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Michael Cath. U. Cemetery
- 20c. LOCATION — City or Town, State: Baltimore, Md.
- 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn
- 22. NAME AND ADDRESS OF FACILITY: E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Coronary Artery Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
- 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
- 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
- 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
- 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
- 28a. DATE OF INJURY (Month, Day, Year)
- 28b. TIME OF INJURY M
- 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
- 28d. DESCRIBE HOW INJURY OCCURED
- 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
- 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
- 29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
- 29b. SIGNATURE AND TITLE OF CERTIFIER: Morris C. Kowalewski MD
- 29c. LICENSE NUMBER: D21022
- 29d. DATE SIGNED (Month, Day, Year): ▶ 5-15-89
- 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 8604 Harford rd GALTO MD 21234
- 31. DATE FILED (Month, Day, Year): MAY 17 1989
- 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasill

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13333

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIE A. SMITH | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 10 / 89 | 3. TIME OF DEATH: 1:40 A.M. M |
| 4. SOCIAL SECURITY NUMBER: 219-07-9035 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4/30/1895 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 1416 Gibson Wood Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1416 Gibson Wood Road | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grammer; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waitress | 16b. KIND OF BUSINESS/INDUSTRY: Hotel | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown Stengle | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Marilyn G. Petraska | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1416 Gibson Wood Road Catonsville, Md. 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jackie M. Shannon | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebral Hemorrhage Heart failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Advanced arteriosclerosis Cardiovascular disease | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): senile | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D04971 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5/10/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Heredia | 413 Commonwealth Ave. Catonsville, Md. 21228 | |
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Pendarvis | |

DHMH-18 Rev 1/89

88 13333

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

89 13334
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BARRY C. SHEEHAN | | | 2. DATE OF DEATH (Month, Day, Year): 5 28 89 | 3. TIME OF DEATH: 3:20 A M |
| 4. SOCIAL SECURITY NUMBER: 216 38 4243 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 48 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4 26 41 | 8. BIRTHPLACE (State or Foreign Country): BALTO, MD. |
| 9a. FACILITY NAME (If not institution, give street and number): 12 Fieldstream Court | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lutherville | | 9c. COUNTY OF DEATH: Baltimore Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTO COUNTY | 10c. CITY, TOWN OR LOCATION: LUTHERVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 12 FIELD STREAM CT. | 10f. ZIP CODE: 21093 | 10g. CITIZEN OF WHAT COUNTRY? US | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): X 5 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Vice President |
| 16b. KIND OF BUSINESS/INDUSTRY: Banking | | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): MICHAEL SHEEHAN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CARMELLA Kahl |
| 19a. INFORMANT'S NAME (Type/Print): DR-H. SCHIRMER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 E UNIV. PKWY |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE | 20c. LOCATION — City or Town, State: BALTO CTY |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: H. Sheehan Conway Jr | 22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. RESPIARATORY ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. HERATIC AND UREIC COMA | 2 WKS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. ANEMIA | |
| | d. METASTATIC CANCER | 1 YR. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: DR. HORST SCHIRMER | 29c. LICENSE NUMBER: D 10 | 29d. DATE SIGNED (Month, Day, Year): ▶5.28.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. H. SCHIRMER 201 E. UNIV. PKWY BALTO 21218 | | |
| 31. DATE FILED (Month, Day, Year): 5 JUN 01 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

88 13331

89 13335

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SANDRA L. SELLS | | | 2. DATE OF DEATH (Month / Day / Year): 05 / 29 / 89 | 3. TIME OF DEATH: 9:45A M |
| 4. SOCIAL SECURITY NUMBER: 307-44-3696 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 49 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 08-25-40 | 8. BIRTHPLACE (State or Foreign Country): Indiana |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: TOWSON |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6706 Maxalea Road | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 8+): 2 years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Certified Public Accountants | |
| 17. FATHER'S NAME (First, Middle, Last): Ralph Lee Strickler | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Shields | |
| 19a. INFORMANT'S NAME (Type/Print): Charles E. Sells | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6706 Maxalea Rd. Baltimore, Md. 21239 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ladoga Cemetery | 20c. LOCATION — City or Town, State: Ladoga, Indiana | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Burnside, Jr | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CEREBRAL ANOXIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. BREAST CARCINOMA WITH BONE METASTASIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Rezazadeh M.D. | | ▶ 05-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HAMIED R. REZAZADEH, M.D. GBMC-6701 NORTH CHARLES STREET

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| JUN 01 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

88 13332

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13336

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD B. SPENCER
2. DATE OF DEATH: MONTH 5 DAY 26 YEAR 89
3. TIME OF DEATH: 1130 A M
4. SOCIAL SECURITY NUMBER: 217-48-7845
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 33 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-02-56
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL - 7620 YORK RD
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTO

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 204 E. GITTINGS AVE
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Communication Specialist
16b. KIND OF BUSINESS/INDUSTRY: Banking
17. FATHER'S NAME (First, Middle, Last): Julian M. Spencer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Christine Maxwell
19a. INFORMANT'S NAME (Type/Print): Mr. Julian M. Spencer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 E. Gittings Ave. Baltimore, Md. 21212
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward Cassidy Jr
22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiogenic Shock | 2 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Cardiomyopathy | 3 months |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | AIDS | 4 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Acute Appendicitis with Periappendiceal Abscess

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO — Limited
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James Whitehurst MD
29c. LICENSE NUMBER: D28625
29d. DATE SIGNED (Month, Day, Year): 5/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): JUN 01 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

88 13330

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13337 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edith G. Simpson | | | 2. DATE OF DEATH (Month, Day, Year): May 26 1989 | 3. TIME OF DEATH: 2:30 PM |
| 4. SOCIAL SECURITY NUMBER: 215 46 9157 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1905 Jan 3 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 41 Libertyparkway (Home) RESIDENCE OF DECEDENT | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Dundalk | 9c. COUNTY OF DEATH: Baltimore |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Dundalk | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 41 Liberty Parkway | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Alexander G. Isennock | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lola McCleary | |
| 19a. INFORMANT'S NAME (Type/Print): Walter Simpson (Son) | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3421 Dunhaven Rd. Dundalk, Md. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Md. 21224 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | | 22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home Inc. 2134 Willow Spring Rd. Dundalk, Md. 21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Congestive heart failure | days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Septicemia | days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | A S C V D | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Bernard J. Yukna MD | D14206 | ▶ MAY 26 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Bernard Yukna MD 59 DUNDALK AVE BALTO MD 21222

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| MAY 30 1989 | Julia Davidson-Kinville |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-13338

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John L. Rosasco | | | | 2. DATE OF DEATH (Month / Day / Year): 5 / 13 / 89 | 3. TIME OF DEATH: 6:10 P M |
| 4. SOCIAL SECURITY NUMBER: 215-40-7854 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 46 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-25-42 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8034 KIMBERLY ROAD | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICIAN | | 16b. KIND OF BUSINESS/INDUSTRY: BETHLEHEM STEEL CORP. | |
| 17. FATHER'S NAME (First, Middle, Last): STEPHEN ROSASCO | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY BENDA | |
| 19a. INFORMANT'S NAME (Type/Print): JUDITH C. ROSASCO | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8034 KIMBERLY ROAD BALTIMORE, MARYLAND 21222 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY 5-16-89 | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gregory E. Reed | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): 5-14-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 111 Penn St., Balto., Md. 21201

31. DATE FILED (Month, Day, Year): MAY 15 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Rudasa

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13339

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Virginia Lee TENNEY

**2. DATE OF DEATH** (Month, Day, Year): May 21, 1989

**3. TIME OF DEATH**: 5:20 p M

**4. SOCIAL SECURITY NUMBER**: 219-10-1237

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 10-16-25

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): Franklin Square Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Rossville

**9c. COUNTY OF DEATH**: Baltimore County

**RESIDENCE OF DECEDENT**

**10a. STATE**: Md.

**10b. COUNTY**: Baltimore

**10c. CITY, TOWN OR LOCATION**: Middle River

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 13119 Rivervan Avenue

**10f. ZIP CODE**: 21220

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Housework

**16b. KIND OF BUSINESS/INDUSTRY**: At Home

**17. FATHER'S NAME** (First, Middle, Last): Thomas Lyons

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Ethel Hullett

**19a. INFORMANT'S NAME** (Type/Print): Blaine Tenney

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13119 Rivervan Ave. Baltimore, Md. 21220

**20a. METHOD OF DISPOSITION**: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Green Mount Crematorium

**20c. LOCATION — City or Town, State**: Baltimore City, Md.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Charles D. Zeiler

**22. NAME AND ADDRESS OF FACILITY**: Charles S. Zeiler & Son Inc. 6224 Eastern Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF LOWER GENITAL TRACT

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CIRRHOSIS OF LIVER

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(1) CHRONIC HYPERTENSION
(2) METASTATIC SPREAD OF CANCER TO LIVER

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: G. Madhavan MD CERTIFYING MD

**29c. LICENSE NUMBER**: D 17692

**29d. DATE SIGNED** (Month, Day, Year): ▶ 5-22-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): M. Raju MD. 201 Ballard Ave. Balto, Md/ 21220

**31. DATE FILED** (Month, Day, Year): MAY 24 1989

**32. REGISTRAR'S SIGNATURE**: Julia Dziedzic Rudnicki

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13340
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARRY (HARRY TULKOFF) TULKOFF | | | | 2. DATE OF DEATH (Month, Day, Year): 5 2 89 | 3. TIME OF DEATH: 0815 M |
| 4. SOCIAL SECURITY NUMBER: 213-34-2162 | 5. SEX: 1 ☒ M 2 ☐ F | 5. AGE (In yrs. last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-01-99 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore Co. General | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown, MD | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7219 PARK HTS. AVE., APT. 305 | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: usa |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRESIDENT | 16b. KIND OF BUSINESS/INDUSTRY: TULKOFF HORSERADISH PRO., CO. |
| 17. FATHER'S NAME (First, Middle, Last): ABRAHAM TULKOFF | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH UNKNOWN |
| 19a. INFORMANT'S NAME (Type/Print): MARTIN TULKOFF | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3404 SHELBURNE RD. BALTO., MD 21208 |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SHAAREI ZION | 20c. LOCATION — City or Town, State: ROSEDALE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joel D. Lewis | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE NON LYMPHOCYTIC LEUKEMIA | 0 minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Ravi MD | 29c. LICENSE NUMBER: D37333 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5. 2. 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI MD, BCGH, RANDALLSTOWN | | |
| 31. DATE FILED (Month, Day, Year): MAY 4 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

89 13341
REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLOTTE TURK | | | | 2. DATE OF DEATH (Month, Day, Year): MAY 7, 1989 | 3. TIME OF DEATH: 10:20 AM |
| 4. SOCIAL SECURITY NUMBER: 218-01-9358 D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 98 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): MAR. 29, 1891 | 8. BIRTHPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): MILFORD MANOR NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: CROSS COUNTRY MANOR APTS. 3323 CLARKS LANE APT. E (21215) | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKER | |
| 17. FATHER'S NAME (First, Middle, Last): HERMAN LINDENBERG | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): STEPHENIA FRISCH | |
| 19a. INFORMANT'S NAME (Type/Print): DR. JULIEN H. TURK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1300 ST. ALBANS RD. BALTIMORE, MD. (21208) | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY | 20c. LOCATION — City or Town, State: REISTERSTOWN, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sydney L. Stillman | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | 2 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cancer Leung | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M B Perlman MD | 29c. LICENSE NUMBER: D139999 | 29d. DATE SIGNED (Month, Day, Year) ▶ MAY 8, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M B PERLMAN MD 5900 OCD COURT RD | | |
| 31. DATE FILED (Month, Day, Year): MAY 12 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 89 13342

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MAE D. TALBOTT (MAE DENTON TALBOTT) | | | 2. DATE OF DEATH (Month, Day, Year): 5 6 89 | 3. TIME OF DEATH: 12:30 PM |
| 4. SOCIAL SECURITY NUMBER: 215-32-0641 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-24-03 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, MD. | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Edenwald/8011 York Rd | 10f. ZIP CODE: 21204 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales | 16b. KIND OF BUSINESS/INDUSTRY: Real Estate | |
| 17. FATHER'S NAME (First, Middle, Last): Benjamin F. Denton | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Lusby | | |
| 19a. INFORMANT'S NAME (Type/Print): Edwin Talbott Jr. | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1314 Doves Cove Rd Towson, MD 21204 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount | 20c. LOCATION — City or Town, State: Balto City | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Stephenson | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld 6500 York Road 21212 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | cardiac pulmonary arrest | 3 min |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | probable intestinal injection | 2-3 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): c. | ASCVD | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Wm Bouchelle MD | 29c. LICENSE NUMBER: D25127 | 29d. DATE SIGNED (Month, Day, Year): 5-6-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wm BOUCHELLE 1900 E NORTHERN PKWY BALT MD 21239

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 9 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-15 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89 13343

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Florence Teal | | | 2. DATE OF DEATH (Month, Day, Year): May 22 1989 | 3. TIME OF DEATH: 1:45 A M |
| 4. SOCIAL SECURITY NUMBER: 216-28-3762 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): April 1, 1901 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): 19701 Graystone Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: White Hall | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: White Hall | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 19701 Graystone Road | | 10f. ZIP CODE: 21161 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): John Carter | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Spinks | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret L. Six | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19701 Graystone Rd., White Hall, MD 21161 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery | 20c. LOCATION — City or Town, State: Freeland, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. J. Hartenstein | | 22. NAME AND ADDRESS OF FACILITY: J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): | 6 mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. | arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): | 10 years |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Donald L. Bortner, M.D. | 29c. LICENSE NUMBER: MD-027002-L | 29d. DATE SIGNED (Month, Day, Year): 5-22-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD L. BORTNER, M.D. 40 SOUTH BROAD ST. NEW FREEDOM, PA. 17349

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): MAY 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Tredon-Landers |

DHMH-16 Rev 1/89

89-13344

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. [redacted]

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edna B. Underkoffler | | 2. DATE OF DEATH (Month, Day, Year): 5 - 14 - 89 | 3. TIME OF DEATH: 8:15 AM |
| 4. SOCIAL SECURITY NUMBER: 213-03-5580 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-25-1894 |
| 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): (Heritage) HERITAGE Nursing Home | 9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3908 Falls Road | 10f. ZIP CODE: 21211 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: CAU. |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Production Worker | 16b. KIND OF BUSINESS/INDUSTRY: Brush Manufactor | |
| 17. FATHER'S NAME (First, Middle, Last): Niobe L. Bechtel | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lizzie S. Bucher | | |
| 19a. INFORMANT'S NAME (Type/Print): William C. Underkoffler | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3908 Falls road Baltimore, Maryland 21211 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynn Burgee Henss | 22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home, 3631 Falls Road, Baltimore, Md 21211 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Cardiac Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. A S C V D | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Theo Patterson MD | 29c. LICENSE NUMBER: D09643 | 29d. DATE SIGNED (Month, Day, Year): ▶ 5-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THEO. C PATTERSON MD 1576 Merritt Blvd Dundalk Md 21222 | | |
| 31. DATE FILED (Month, Day, Year): MAY 19 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

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